

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



SUSAN G. KOMEN®
COLORADO

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Executive Summary

Introduction to the Community Profile Report

Susan G. Komen® Colorado's mission is to save lives and end breast cancer forever. The nonprofit organization is a local Affiliate of Dallas-based Susan G. Komen, which was founded in 1982 as the result of a promise Nancy G. Brinker made to her sister, Susan G. Komen – who died from breast cancer at 36 – to do everything in her power to end breast cancer forever.

Komen Colorado was formed in December 2013 after a merger between the Komen Denver, founded in 1992, and Komen Aspen, founded in 1991. In keeping with Komen's history as a locally driven, community-based organization, both Affiliates were established out of a desire to raise awareness about breast cancer, raise money to help research a cure for a devastating disease, and remove barriers to breast cancer care experienced by family members and neighbors. Both Affiliates were founded and managed for many years by dedicated volunteers from each community. Yet as the breast cancer needs of the communities served by the Affiliate evolved, so too did the organization. While the Affiliate is now professionally staffed, volunteers remain the heart of the organization's success and serve in leadership, fundraising, administrative and program implementation roles.

While the Affiliate's structure and reach have evolved through the years, its focus has not. Komen Colorado remains committed to saving lives and ending breast cancer forever by:

- Empowering people to make healthy decisions about their breast health;
- Ensuring quality care for all; and
- Energizing science to find the cures.

The Affiliate does this by:

- Reducing medical expenses for underserved Coloradans in need of breast cancer care by investing 75 percent of net funds raised every year into local nonprofit health care clinics, hospitals and community-based organizations;
- Delivering volunteer-based and grant-funded education about breast health and breast cancer risk and appropriate screening recommendations;
- Advocating for equal access to life-saving breast cancer care and research funding at the state and national levels;
- Partnering with state agencies, corporate and individual donors, volunteers, and medical professionals to reduce disparities in breast cancer outcomes; and
- Investing 25 percent of net funds raised annually in Komen's Research Programs.

As of 2015, Komen Colorado had contributed \$14.7 million for breast cancer research and invested an additional \$41 million in community-based organizations to provide breast cancer education, screening, treatment and support programs in Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Eagle, Garfield, Gilpin, Jefferson, Larimer, Logan, Morgan, Park, Phillips, Pitkin, Sedgwick, Summit, Washington, Weld, and Yuma Counties (Figure 1).

KOMEN COLORADO SERVICE AREA

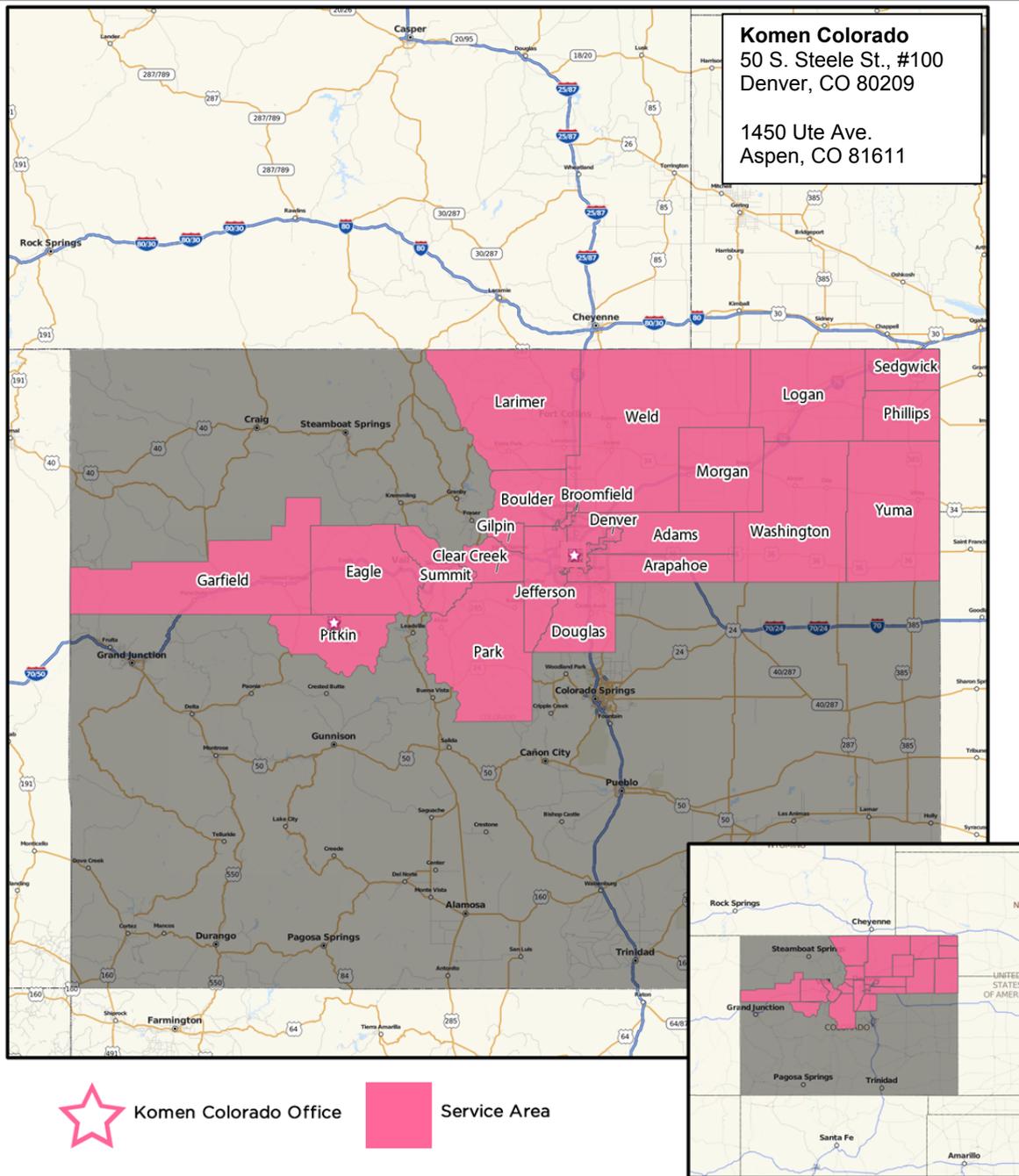


Figure 1. Susan G. Komen Colorado service area

The organization also facilitates multiple regional coalitions to promote public education about the risks of breast cancer, share best practices and clinical advances in breast cancer screening and treatment guidelines, and facilitate clients' access to appropriate health care services along each stage of the breast health continuum of care (Figure 2). The coalitions have representation from Komen Colorado grant recipients, the Colorado Department of Public Health and

Environment (CDPHE), the Colorado Department of Health Care Policy and Financing (HCPF), the American Cancer Society (ACS), and other community stakeholders.

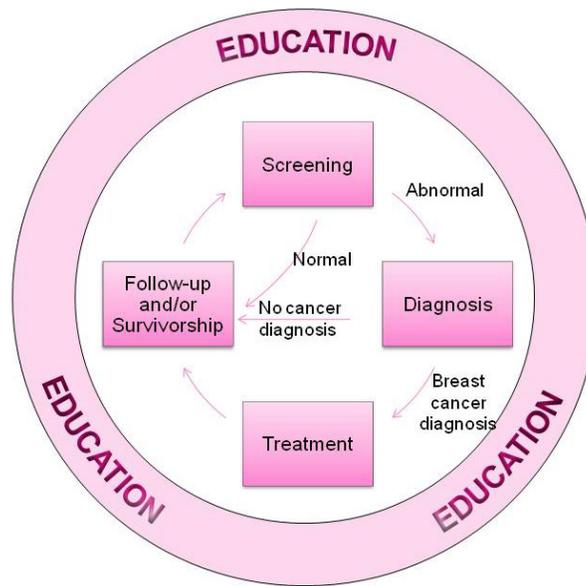


Figure 2. Breast cancer Continuum of Care (CoC)

Using data available in 2014, Komen Colorado synthesized evaluations of quantitative breast cancer data, an assessment of breast health care providers within the Affiliate’s service area, an evaluation of the early effects of health care reform, and analysis of community input about barriers to breast cancer care, to:

1. Identify communities at risk of failing to achieve the breast cancer screening, late-stage diagnosis, and death rate targets established through the U.S. Department of Human Service’s Healthy People 2020 program (HP2020),
2. Align the Affiliate’s efforts with those of Colorado’s cancer prevention and early detection initiatives, and
3. Prioritize the Affiliate’s resource investments for the next four years.

Komen Colorado has developed this 2015 Community Profile to summarize the service area’s breast cancer needs through 2020. The Affiliate uses the Community Profile as a foundation for developing the organization’s strategic and operational planning and informs the Affiliate’s grantmaking, education/outreach, collaboration, public policy, and development priorities. By focusing on these priorities, Komen Colorado can ensure that resources and programs contribute toward achieving the following outcomes throughout its service area:

- Increase in screening percentages and access to care
- Reduction in late-stage diagnosis and breast cancer death rates
- Reduction in disparities in breast cancer outcomes between various populations
- Enhanced quality of life for patients and survivors
- Patients’ ability to progress along the breast cancer continuum of care in their local communities is enhanced
- Individuals demonstrate increased understanding of and decision-making about breast cancer risk, screening recommendations, and screening behaviors

The Community Profile should be used by community partners to:

- Understand Komen Colorado’s assessment of which populations are most at-risk of dying from breast cancer and social determinants of health that contribute to that risk;
- Identify needs and gaps in the health care system within the Affiliate’s service area;
- Identify community assets that can help fill gaps and reduce disparities in breast cancer outcomes; and
- Better understand what the public knows, thinks and does about breast cancer and recommended breast health care.

Komen Colorado and Breast Cancer After Health Care Reform

Since the Denver-metropolitan and Aspen Affiliates last published Community Profiles in 2011, state and federal laws regulating health insurance coverage and health care systems’ provision of services have changed dramatically. The Affordable Care Act, Colorado’s decision to increase the income level for Medicaid eligibility, and a multi-year commitment by public and private partners to make Colorado the healthiest state in the nation have dramatically changed the way Colorado women and men access breast cancer screening, diagnostic and treatment services in their communities (Table 1). It is within this changing health care landscape that Komen Colorado operates – as a funder of safety-net services for those without other resources and as an advocate to ensure breast cancer continues to be recognized as a public health priority that has economic consequences for families and communities affected by the disease.

The most important changes affecting how Coloradans access breast cancer care are:

- Medicaid expansion for eligible Coloradans who earn up to 138 percent of the federal poverty level (FPL; \$16,105 for a one-person household; \$32,913 for a four-person household using 2014 FPL figures)
- Financial assistance for eligible Coloradans who earn between 138-400 percent FPL to purchase commercial health insurance through the Connect for Health Colorado marketplace (up to \$46,680 for a one-person household; \$95,400 for a four-person household)
- Implementation of regional collaborative care organizations (RCCOs) to facilitate care coordination across health care systems and between primary and specialty care providers
- Implementation of payment model reform to change how providers are reimbursed for care by de-emphasizing volume of procedures and emphasizing patient outcomes
- Insurance coverage requirements, including:
 - Coverage for routine mammography beginning at age 40 for women of average risk and genetic testing and counseling for women and men at increased risk as preventive services that cannot be charged out-of-pocket expenses
 - Banning the use of gender or health status as rating criteria to determine premiums
 - Banning exclusions based on pre-existing conditions
 - Limiting annual deductibles for certain out-of-pocket expenses
 - Removing annual or lifetime limits that insurance carriers will pay toward covered benefits

A substantial proportion of women below 138 percent of the federal poverty level who previously received breast cancer care funded by Affiliate grants or the Women’s Wellness Connection

(WWC), a publicly-funded program to provide breast cancer screening and diagnostic services to qualifying low-income women, are now enrolled in Medicaid. While an inventory of breast health providers conducted by the Affiliate revealed Medicaid is an accepted form of payment for patients, Komen Colorado has received anecdotal reports that specialty providers like surgeons and oncologists have stopped accepting new Medicaid patients because of relatively low reimbursement rates compared to those for privately insured patients. The reported lack of facilities willing to accept new Medicaid patients could have an adverse effect on breast health outcomes because women and men in need either are turned away or, if notified of a long wait for services, forego care.

Table 1. Summary of providers by stage of breast cancer continuum of clinical care

	Screening	Diagnostics	Treatment	Support Services**
Number of Providers*	237	90	54	103
Number Accepting Medicaid	117	52	32	83
<small>* "Provider" excludes facilities that provide only patient navigation services but do not provide clinical services (i.e., clinical breast exams, mobile or in-center mammography, diagnostic procedures, radiation, chemotherapy or surgery) ** Complementary care includes support groups, side effect management, psychosocial counseling, exercise/nutrition, financial assistance, complementary therapies, legal services, or end-of-life care</small>				

Concurrent with implementation of health care reform have been evolutions in the administration of two safety-net programs for breast and cervical cancer care. The WWC program, administered through CDPHE and jointly funded through state and federal funds, covers costs of breast and cervical cancer screening and diagnostic services for women aged 40-64 who earn too much for Medicaid but less than 250 percent FPL (\$29,175 for a one-person household; \$59,625 for a four-person household) and are uninsured, do not have insurance plans that cover medically recommended services, or cannot afford out-of-pocket expenses charged through their private plans; and meet state residency requirements. Women who meet those same age and income requirements, are uninsured, and meet federal residency requirements to receive public benefits, can enroll in a special Medicaid program called the Breast and Cervical Cancer Treatment (Medicaid BCCP) program funded through federal dollars and fees collected by the purchase of breast cancer awareness license plates. Women diagnosed with breast or cervical cancer who meet eligibility criteria may be enrolled in Medicaid BCCP regardless of the facility of diagnosis; this is a recent change from previous policy, which restricted enrollment to women who were diagnosed at WWC sites.

Implementation of health care reform has changed demand for financial support to offset costs of care for previously uninsured individuals. Since 2014, when Medicaid was expanded in Colorado and financial assistance was made available for commercial health insurance plans sold through the Connect for Health Colorado marketplace, the Affiliate experienced:

- Moderate decreases in demand among:
 - Women and men younger than age 40 who earn less than 138 percent of the federal poverty level who are now eligible for Medicaid
 - Men aged 40-64 who earn too much to qualify for Medicaid but, because of their gender, don't qualify for WWC or Medicaid BCCP, as these individuals increasingly purchase private plans through Connect for Health Colorado
- No change in demand among women and men who are not eligible for Medicaid, WWC or Medicaid BCCP, or to purchase private insurance through Connect for Health Colorado, regardless of income

As formerly uninsured women and men adjust to having either Medicaid or commercial insurance, Komen Colorado has identified the following as recurring challenges of health care reform:

- Questions about whether there are sufficient providers to serve newly insured patients; this is tied to both sufficiency of primary and oncology providers to meet the volume of newly insured patients as well as whether providers are accepting new patients – regardless of insurance type
- Confusion about whether providers are considered “in-network” – especially among lower-priced bronze- and silver-metal commercial insurance plans that may achieve cost savings by excluding specialty care providers like oncologists and breast surgeons
- Lack of clarity about the legality of commercial carriers using high-cost, co-insurance fee structures for cancer medications rather than more affordable, flat-rate co-pay structures
- Lack of understanding about how to use health insurance and navigate health care systems among newly insured individuals; often these individuals struggle to identify in-network providers; understand scope of breast cancer coverage, co-payment, coinsurance and deductible responsibilities; and self-navigate across health care systems to remain in the CoC in their community

These questions, as well as identification of women and men who are not eligible to participate in Medicaid expansion or who are unable to purchase commercial health plans, provide direction for the Affiliate’s grantmaking and advocacy efforts.

Communities At-Risk for Adverse Breast Cancer Outcomes

Against this backdrop of an evolving health care marketplace where increased health insurance coverage is expected to result in improved overall health, Komen Colorado continues to identify communities most at-risk for disparities in breast cancer outcomes attributable to such social determinants of health as race, ethnicity, lack of insurance coverage, educational attainment, geographic or linguistic isolation, immigration status, and income. Because Komen Colorado’s service area covers 72 percent of the state’s population, positive changes in breast health care decision-making behaviors, early detection of breast cancer, and survivorship rates within the Affiliate’s service area will substantively affect the state’s capacity to meet the breast health targets established by HP2020. To identify populations most at risk of failing to achieve HP2020 objectives, the Affiliate reviewed national breast cancer data and state-level data about disparities in how Colorado communities access health care.

Komen Colorado evaluated breast cancer incidence, death rates, and late-stage diagnosis data for the years 2006 through 2010, as well as screening mammography frequency data from 2012. The Affiliate also assessed social determinants of health that have been demonstrated to contribute to adverse breast health outcomes. The Affiliate also reviewed reports specific to health care accessibility, health insurance utilization, and regional variances in cost of living in Colorado. This supplemental information enhanced the Affiliate’s ability to prioritize communities most at-risk for failing to achieve HP2020 targets. Full source information is available in the Quantitative Data Section of the 2015 Community Profile Report.

Based on the data review, Komen Colorado prioritized the following four target communities:

- **Hispanic/Latina Women**
- **Women living in rural northeast Colorado (Colorado Health Statistics Region 1)**
- **Women living in mountain and resort communities (Clear Creek, Eagle, Garfield, Gilpin, Park, Pitkin and Summit Counties)**
- **Women living in medically underserved communities within Front Range counties (Adams, Arapahoe, Broomfield, Denver, Douglas, Larimer and Weld Counties)**

To understand how these communities access – or are unable to access – breast cancer care, the Affiliate conducted an inventory of providers within the 22 counties served by Komen Colorado that offer education about breast cancer risk and navigation into care, breast cancer screenings, diagnostic procedures, treatment for women and men diagnosed with the disease, and support services for those undergoing treatment. Komen Colorado evaluated accessibility of care through the providers by using a survey instrument to track:

- Types of payment accepted for patient/client care, which the Affiliate used to evaluate sufficiency of providers for Colorado’s expanded Medicaid population;
- Whether the facility participates in a regional coordinated care organization (RCCO) or payment reform model being piloted in Colorado under the Affordable Care Act;
- The household income level used by each organization to determine patient/client eligibility for charity care;
- Estimates of non-citizens served; and
- Languages other than English used with patients/clients.

While the Affiliate identified locations that delivered services in each geographically based target community, proximity to facilities emerged as a consistent barrier to care for individuals in rural northeast Colorado, mountain and resort communities, or more rural or medically underserved parts of Front Range counties.

Komen Colorado also retained Corona Insights, a Denver-based market research and strategic consulting firm, to gather community input to supplement the findings of the quantitative data and health systems. Corona Insights used two research methods to explore the community’s perception of barriers to breast cancer care within the four target communities: (1) an online survey of 116 breast health providers and (2) in-depth interviews with 54 providers.

The key questions and variables that were assessed with each method were (barriers to) access and utilization of services along the breast cancer continuum of care. The online survey allowed the Affiliate to identify themes in barriers to care, while the key informant interviews allowed the Affiliate to understand nuances of the top barriers that were identified and solicit suggestions to overcome those barriers.

To understand nuances for each of the above barriers, Corona Insights and Komen Colorado staff completed phone interviews with breast health providers that serve each target community. Barriers specific to each target community are summarized in the discussion of key findings for each community; however, the following recurred as areas for Affiliate intervention:

- Communicate with individuals directly about financial resources that are available and where to go to access those resources; however, many providers struggled with the tradeoffs of investing Affiliate resources toward education versus offsetting direct costs of care, with most concluding that patient care should trump outreach

- Partner more closely with staff from Women’s Wellness Connection (WWC), the Medicaid Breast and Cervical Cancer Treatment Program (Medicaid BCCP), and county health departments where BCCP enrollment applications are processed to train non-WWC providers about updates in Medicaid BCCP eligibility
- Help reduce confusion among providers and patients about which breast cancer screening guidelines to follow and why
- Provide continued support for undocumented individuals who have few resources other than Komen Colorado to pay for the costs of breast cancer screening and treatment
- Assist rural and remote areas to increasing availability of services and decrease transportation-related challenges.

For each target community, the Affiliate synthesized key findings of the quantitative breast cancer indicators, strengths and weaknesses of the breast health care system revealed by the provider inventory, and community stakeholders’ identification of key barriers to care to identify priorities for action through 2019. In identifying these priorities, the Affiliate considered:

- Could organizational allocation of philanthropic, educational/outreach, volunteer, and collaborative resources result in changes consistent with the intended outcome?
- Does the priority leverage the Affiliate’s existing organizational strengths?
- Are there opportunities to leverage resources and expertise from existing or potential new partners?

Below is a summary of key findings for each target community, along with identification of priorities Komen Colorado aims to achieve through targeted investment of its resources through 2019. Komen Colorado welcomes collaboration from community partners to join efforts to improve breast cancer outcomes in the Affiliate service area.

Key Findings and Plans for Action

Key Findings & Plan for Action: All target communities

The 2015 Community Profile revealed barriers to care that affect all target communities, suggesting a need for the Affiliate to develop global priorities and objectives for its grantmaking, education and outreach, public policy, collaboration and development efforts. These common barriers that contribute to late-stage diagnosis include:

- Immigration status
- Lack of insurance
- Fear of a diagnosis or lack of knowledge about breast cancer treatment
- Transportation/distance-to-care
- Securing time off work
- Perceived cost of care
- Screening-specific:
 - Lack of knowledge about breast health
 - Lack of knowledge about insurance coverage for screening procedures

Komen Colorado Mission Action Plan: Global Challenges	
Priority: Affiliate will engage in education, collaboration, and advocacy activities to ensure breast cancer perspective is considered by health-oriented or community foundations, policymakers, and other community stakeholders seeking to increase health care coverage, affordability, accessibility, and medically recommended utilization.	
Objective 1	Partner with community stakeholders to achieve 90 percent insurance enrollment for all eligible populations by 2017.
Objective 2	By July 2016, develop plan to partner with philanthropic, business, government, and other nonprofit stakeholders to include breast cancer care in patient navigation, health care workforce development, and health care and health insurance literacy efforts benefiting Colorado's medically vulnerable communities.
Objective 3	By July 2016, Affiliate public policy and mission initiatives committees will develop a position statement on immigration status as a barrier to breast health care.
Objective 4	By July 2016, Affiliate will develop position statements on poverty and educational attainment correlating with mammography frequency in Colorado to highlight social determinants of health that contribute to late-stage diagnosis.
Objective 5	By July 2016, partner with American Cancer Society, Colorado Cancer Coalition, Colorado Department of Health Care Policy and Financing and other stakeholders to provide transportation assistance for cancer patients.
Objective 6	By December 2015, assess breast cancer objectives in Colorado Cancer Plan to align with Affiliate's grantmaking, education and public policy activities.

Key Findings & Plan for Action: Hispanic/Latina women

Komen Colorado has selected Hispanic/Latina women as a target community because of lower screening percentages seen in these women compared to the Affiliate service area as a whole, as well as the presence of social determinants of health that adversely affect their breast health outcomes. While the Hispanic/Latina population in the Affiliate's service area experiences lower age-adjusted rates for breast cancer incidence, death, and late-stage diagnoses compared to non-Hispanic/Latina populations, the trend for late-stage diagnoses is increasing at 5.9 percent among Hispanic/Latina women compared to just 1.8 percent for non-Hispanic/Latina women.

Hispanic/Latina populations comprise 21.2 percent of the Affiliate's service area – a percentage expected to increase through 2020 according to demographic forecasts. Overall, only 59.2 percent of Hispanic/Latina women in the Affiliate service area between the ages of 40 and 74 report having had a mammogram in the last two years – far below the rate of 70.8 percent of non-Hispanic/Latina women and the overall rate of 69.1 percent of women within the service area. Among women aged 50-74 within the Affiliate's service area, the self-reported screening percentage for Hispanic/Latina women in the last two years was slightly higher at 65.3 percent, although that percentage is still lower than the non-Hispanic/Latina rate of 74.2 percent and 73.2 percent for the Affiliate service area overall. Because early and regular screening has been demonstrated to increase detection of early stage breast cancer, these lower screening percentages among Hispanic/Latina women could contribute to the rising late-stage diagnosis rate.

In addition, an analysis from the Colorado Health Institute showed 58.1 percent of Hispanic/Latino adults in Colorado “have annual family incomes at or below 200 percent of the federal poverty level (FPL) - about 20 percentage points more than non-Hispanics.” Moreover, the 2013 Colorado Health Access Survey also revealed a 14.5 percentage-point gap in health insurance coverage between Hispanic/Latino and non-Hispanic/Latino Coloradans. These are issues of concern for Komen Colorado, as data from the 2012 Colorado Behavioral Risk Factor Surveillance System indicate that household income and insurance status also correlate to breast cancer screening percentages: 74.2 percent of women aged 40-74 above 200 percent FPL received a mammogram in the previous two years compared to less than 56 percent of those under 200 percent FPL, and 72.8 percent of women with insurance received a mammogram while just 38.3 percent of uninsured women reported doing so.

Through a health system analysis and qualitative data-gathering, the Affiliate sought insight to answer the following key questions:

1. Do Hispanic/Latina women experience different barriers to care than their non-Hispanic/Latina counterparts?
2. How does immigration status inhibit some Hispanic/Latina women from entering or continuing through the breast cancer continuum of care?

Qualitative research revealed that Hispanic/Latina women faced the same barriers to care as non-Hispanic/Latina women in each of the geographically based target communities. However, there are some additional issues for this population, including immigration status and language/cultural barriers (Table 2). While many providers have some form of Spanish-language services, there is still a need for more culturally sensitive care.

Since the passage of the Affordable Care Act, providers serving large Hispanic/Latina populations were least likely to report an increase in patients receiving breast cancer treatment, which might reflect how immigration status can interfere with treatment. Immigration status prevents some from seeking care because this population fears being turned over to immigration authorities. Further, women who do not meet residency requirements do not have access to Medicaid, private insurance sold through Colorado’s marketplace, or other types of financial assistance.

Table 2. Most common barriers to receiving breast cancer care for Hispanic/Latina women, based on stage of the clinical continuum of care

Screenings	Diagnostics	Treatment
<ul style="list-style-type: none"> • Immigration status • Fear of diagnosis and/or treatment • Lack of knowledge that screenings are covered without a co-pay or deductible for people with insurance • Lack of knowledge about breast health • Lack of insurance 	<ul style="list-style-type: none"> • Securing time off work • Lack of insurance • Immigration status • Fear of the diagnosis and/or treatment • Perceived cost of care 	<ul style="list-style-type: none"> • Immigration status • Lack of insurance • Perceived cost of care • Securing time off work • Transportation

Komen Colorado Mission Action Plan: Hispanic/Latina Women	
Priority: Reduce barriers that may contribute to increased late-stage diagnosis rates among Hispanic/Latina women within Affiliate service area.	
Objective 1	By 2020, increase the requirement for organizations that receive screening/diagnostic grants to ensure 50 percent of individuals served are rarely/never screened women an increase from a baseline of 35 percent of individuals served.
Objective 2	Beginning in FY16-17, solicit applications from eligible organizations to support Spanish-dominant and bilingual breast cancer education and navigation-into-screening programs in either (a) counties where Hispanic/Latina women comprise at least 25 percent of the adult female population or (b) counties or health statistics regions where late-stage diagnosis rates among Hispanic/Latina women are substantially higher than in other populations.
Objective 3	By July 2016, incorporate third-party research findings about preferred languages for medical information among Hispanic/Latina communities into Affiliate’s education efforts.

Key Findings & Plan for Action: Women living in rural northeast Colorado (Colorado Health Statistics Region 1)

Komen’s Colorado’s designation of rural northeast Colorado includes Logan, Morgan, Phillips, Sedgwick, Washington and Yuma Counties (referred to Colorado Health Statistics Region 1 or HSR 1). As of 2010, the rural region had an estimated population of 11,051 women aged 40-64, a demographic projected to increase by 2.4 percent by 2020. Because of the rural nature of the region, county-specific breast cancer data are often too small to analyze.

However, regional analysis by the Colorado Cancer Registry calculated the five-year estimated annual percent change in female breast cancer death rates is rising by 9.9 percent. In addition, the counties in this region have an older female population, higher poverty, and lower WWC screening percentages compared to the Affiliate service area. Regional median incomes and insurance coverage rates – indicators of mammography screening frequency – also were low in this region. The 2013 Colorado Health Access Survey from the Colorado Health Institute reported that HSR 1 had the highest percentage of uninsured Coloradans and 22.7 percent of the region’s insured residents unable to meet co-pays, deductibles, and other patient responsibilities for their health care.

Through a health system analysis and qualitative data-gathering, the Affiliate sought insight to answer the following key question:

1. What are the nuances related to the limited number of breast health care providers in this region that contribute to low screening percentages?

Limited access to medical facilities, exacerbated by economic barriers to care for low-income and uninsured individuals, makes it difficult for women to access or remain in the breast cancer continuum of care within this region. Residents in these counties are particularly affected by transportation/distance-to-care barriers, with some women needing to travel up to 100 miles to access surgical, radiation, or medical oncology services. For those who are uninsured or underinsured and need charity care, often the travel required is even farther.

Breast health providers also identified a regional predisposition against preventive care as a barrier both for the older farmer/rancher residents of this region and for immigrant residents.

Residents' immigration status and lack of health insurance also were identified as substantial barriers to care in the region (Table 3). Although preliminary enrollment data from Medicaid expansion and the first year of purchase of private plans through Connect for Health Colorado, Colorado's health insurance marketplace, indicate a decline in the region's uninsured population, breast health providers in the community did not report experiencing an increase in patients seeking preventive care. As indicated among other target communities, because undocumented immigrants are ineligible for public insurance programs or commercial plans sold through the marketplace, lack of insurance is expected to remain a barrier for this population.

Qualitative data also revealed provider organizations serving rural northeast populations were less likely than providers in some of the other regions to provide education about breast health/health care generally. It was also less common for patient navigators in this region to be required to go through training.

Table 3. Most common barriers to receiving breast cancer care for women in rural northeast Colorado, based on stage of the clinical continuum of care

Screenings	Diagnostics	Treatment
<ul style="list-style-type: none"> • Knowledge about breast health • Lack of knowledge that screenings are free for people with insurance • Immigration status • Lack of insurance, and • Transportation 	<ul style="list-style-type: none"> • Fear of diagnosis and/or treatment • Lack of insurance • Distance to travel for specialty services • Immigration status • Lack of understanding of medical terminology • Securing time off from work 	<ul style="list-style-type: none"> • Lack of insurance • Immigration status • Perceived cost of care • Transportation • Distance to travel for specialty services

Komen Colorado Mission Action Plan: Rural Northeast Colorado	
Priority: Reduce barriers that may contribute to increased breast cancer deaths in rural northeast Colorado.	
Objective 1	By 2020, increase the requirement for organizations that receive screening/diagnostic grants to ensure 50 percent of individuals served are rarely/never screened women, including women from Logan, Morgan, Sedgwick and Yuma Counties, an increase from a baseline of 35 percent of individuals served.
Objective 2	By May 2016, evaluate Affiliate’s community grant categories to assess whether regional applicants that provide screening, diagnostic and treatment services should be able to apply for a medical continuum of care grant rather than being required to apply for multiple direct service grants.
Objective 3	By September 2015, work with Rural Solutions and the Northeast Colorado regional Komen coalition to assess effectiveness of current Affiliate funding to provide financial support to offset transportation costs for breast cancer care.
Objective 4	By December 2015, leverage Northeast Colorado Breast Health Coalition to re-engage breast health care providers, WWC, and other key stakeholders that serve rural northeast Colorado to evaluate potential impact for mobile mammography unit, financial assistance to offset transportation barriers, and other evidence-based interventions to address transportation/distance-to-care barriers in the region.
Objective 5	By December 2016, develop an education and outreach effort targeting regional primary care providers, community health resource centers, and/or individuals to provide continuous education about Komen-advised breast screening protocols.

Key Findings & Plan for Action: Women living in mountain and resort communities

Komen Colorado considers residents of Clear Creek, Eagle, Garfield, Gilpin, Park, Pitkin and Summit Counties as one target community because of common characteristics that inhibit residents’ ability to access breast health care services. The counties are characterized by isolated mountain and resort towns, or sporadically developed residential communities in unincorporated parts of the counties, that depend on tourism for their economies. A number of factors that adversely affect overall breast health outcomes are prevalent within these counties, including: an aging female population; rural, isolated communities; high costs of living that reduce lower-income residents’ disposable income to allocate to breast health crises; linguistic isolation; residency barriers in some counties; and the overall lack of medical services for low-income and uninsured individuals.

County-level breast cancer data are either unavailable or suppressed because of the small numbers. Relevant available data includes:

- Garfield County has significantly lower screening percentages than the Affiliate service area as a whole and has a late-stage diagnosis rate that is rising at 17.3 percent.
- Eagle County has a substantially lower WWC screening percentage than the State of Colorado, which is a concern considering the county’s population of women aged 40-64 is expected to swell by 30.5 percent between 2010 and 2020.
- In Park County, only 55.6 percent of women between the ages of 40 and 74 report having had a mammogram in the last two years, and the county lost its lone primary care provider in summer 2014.

- Summit County is expected to experience a 20.5 percent increase in the number of women aged 40 to 64 between 2010 and 2020 – but has limited health care facilities.
- Clear Creek has a substantially larger female population between the ages of 40 and 64 compared to the Affiliate territory as a whole, is considered 100 percent rural and is also classified as 100 percent medically underserved.
- Pitkin County has a substantially larger female population between the ages of 40 and 64 than the Affiliate as a whole and 44 percent of the county is considered rural.

Through a health system analysis and qualitative data-gathering, the Affiliate sought insight to answer the following key questions:

1. What are the nuances related to the limited number of breast health care providers in this region that contribute to adverse breast health outcomes among certain populations?
2. How does regional cost of living act as a barrier to breast cancer care differently than in other regions within the Affiliate service area?

Interviews with providers from mountain and resort towns underscore barriers stemming from regional income inequality, where the already limited availability of providers is exacerbated for those with Medicaid or without insurance. The high cost of living in the area has also created a situation where those who are very low-income are not considered low-enough income to qualify for Medicaid or financial assistance to offset health insurance expenses. Additionally, they often cannot afford the monthly payments or out-of-pocket costs associated with a high-deductible plan. Providers also cited patients’ fear of health care costs as a barrier to seeking or following-up with care. The greatest needs in this region are affordable services for these populations, and financial support across the continuum of care for those who are underinsured.

Provider organizations serving larger mountain and resort town populations were the least likely to provide education about breast health compared to providers in other regions within the Affiliate service area (Table 4). Of concern to the Affiliate was a recurring reluctance among providers in the region to conduct additional outreach because of questions about whether the region’s breast health care system had capacity to support more patients. Providers in mountain and resort communities also were more likely than other regions to have a full-time translator for their non-English-speaking patients.

Table 4: Most common barriers to receiving breast cancer care for women in mountain and resort communities, based on stage of the clinical continuum of care

Screenings	Diagnostics	Treatment
<ul style="list-style-type: none"> • Knowledge about breast health • Fear of diagnosis and/or treatment • Perceived cost of care • Lack of knowledge that screenings are free for people with insurance • Lack of insurance 	<ul style="list-style-type: none"> • Lack of insurance • Fear of diagnosis and/or treatment • Perceived cost of care • Transportation • Securing time off from work 	<ul style="list-style-type: none"> • Lack of insurance • Transportation • Distance to travel for specialty services • Perceived cost of care • Securing time off from work

Komen Colorado Mission Action Plan: Mountain and Resort Communities	
Priority: Increase affordable access to the full continuum of care by reducing transportation and cost barriers and increasing outreach/education for uninsured and under-insured populations.	
Objective 1	By January 2016, evaluate Affiliate's provision of grant funding to offset costs for breast cancer treatment in Eagle, Garfield and Pitkin Counties and work with regional providers to determine future regional treatment needs, including funding to offset transportation-related expenses.
Objective 2	Beginning with the FY 16-17 grant cycle, increase income threshold for individuals in mountain and resort communities to benefit from Affiliate grant-funded projects to at least 300 percent FPL and annually evaluate capacity to increase threshold to 400 percent by 2020.
Objective 3	By 2020, increase the requirement for organizations that receive screening/diagnostic grants to ensure 50 percent of individuals served are rarely/never screened women, an increase from a baseline of 35.
Objective 4	By May 2016, evaluate Affiliate's community grant categories to assess whether regional applicants that provide screening, diagnostic and treatment services should be able to apply for a medical continuum of care grant rather than being required to apply for multiple direct service grants.
Objective 5	By June 2016, evaluate Affiliate's education and outreach program targeting Hispanic/ Latina populations in Eagle, Garfield and Pitkin Counties to understand impact on increase in screenings among rarely/never screened women, need for Spanish-only versus bilingual outreach, and whether there is sufficient overall and Komen-funded capacity to meet resulting demand for care.
Objective 6	By December 2016, develop an education and outreach effort targeting regional primary care providers, community health resource centers, or individuals to provide continuous education about Komen-advised breast screening protocols.

Key Findings & Plan for Action: Women living in medically underserved communities within Front Range counties

Adams, Arapahoe, Broomfield, Denver, Douglas, Larimer and Weld Counties will be home to 70.1 percent of women aged 40-64 within the Affiliate service area by 2020. All of these counties except Weld County are expected to fail to meet the HP2020 target for late-stage diagnosis rates. Weld is not expected to meet the HP2020 target for breast cancer mortalities. Moreover, the late-stage diagnosis rate for Black/African-American women in Komen Colorado's service area is increasing at a rate of 8.9 percent annually - compared to an annual increase of 2.0 percent for the service area. Among Asian/Pacific Islanders, the late-stage diagnosis rate is increasing at 27.6 percent annually. Among American Indian/Alaska Native populations, just 52.8 percent of women aged 40-74 reported receiving a mammogram within the preceding two years. These counties are home to the majority of those populations within the Affiliate's service area.

Because of the large total population within these Front Range counties, Komen Colorado will narrow its interventions in these counties to:

- Populations whose late-stage diagnosis trend rate is significantly higher or whose mammography screening percentage is significantly lower than the Affiliate service area; and

- Individuals with lower incomes who are uninsured or underinsured and who live in medically underserved or rural areas within the counties, households with incomes less than 250 percent of the federal poverty level, or linguistic isolation; are foreign-born; or have lower educational attainment than the Affiliate service area.

While interviews with Front Range providers revealed a more comprehensive and more complex health care system than what is available in the rural northeast or the Mountain and resort regions, the greater number of available resources does not mean sufficiency to meet need among un- and underinsured communities. Navigating the Front Range health care system also can become more complicated depending on insurance status. Many providers for the insured are linked to a particular insurance network, and other providers may limit the number Medicaid/Medicare patients they see. For patients who are unfamiliar with the health care system, the need to visit different facilities that each have different financial-assistance qualification protocols can be overwhelming. While the need for patient navigation was expressed by providers in all regions, it was particularly emphasized by Front Range providers. In addition, low-income, and particularly undocumented, individuals in this region have little ability to negotiate time off work for an appointment, and risk losing wages for any time that is taken. Public transportation is more widely available but requires more time than using one's own car (Table 5).

In addition to structural barriers, some providers pointed to psychological or knowledge-based barriers, such as fear and misinformation, preventing patients from seeking care. Many fear the costs of care, and may refuse treatment or fail to seek care because they assume they cannot afford it. Many patients and providers are not aware of the financial resources that may be available, and others may feel there is a stigma associated with accepting assistance.

In the Front Range, many of the underserved are foreign-born, including refugee populations from various countries, as well as immigrants, both documented and undocumented. Barriers for these groups are compounded for those who speak a language other than English or Spanish. Unfamiliarity with the concept of preventive care, and certain taboos about breasts, also were identified as contributors to late-stage diagnoses among these populations.

Table 5. Most common barriers to receiving breast cancer care for medically underserved women in Front Range communities, based on stage of the clinical continuum of care

Screenings	Diagnostics	Treatment
<ul style="list-style-type: none"> • Lack of knowledge about breast health • Fear of the diagnosis and/or treatment • Immigration status • Lack of knowledge that screenings are free for people with insurance • Prioritizing other family members' health 	<ul style="list-style-type: none"> • Lack of insurance • Perceived cost of care • Fear of the diagnosis and/or treatment • Securing time off work • Transportation 	<ul style="list-style-type: none"> • Lack of insurance • Perceived cost of care • Transportation • Securing time off from work • Immigration status

Komen Colorado Mission Action Plan: Front Range Counties	
Priority: Reduce barriers that may contribute to late-stage diagnosis and/or lower screening percentages between Black/African-American, API and AIAN women and other ethnic groups.	
Objective 1	By 2020, increase the requirement for organizations that receive screening/diagnostic grants to ensure 50 percent of individuals served are rarely/never screened women, including Black/African American, Asian/Pacific Islander, and American Indian/Alaska Native women, an increase from a baseline of 35 percent of individuals served.
Objective 2	Beginning in FY16-17, solicit applications from eligible organizations to support culturally competent and linguistically appropriate breast cancer education and navigation-into-screening programs targeting Black/African-American, Asian/Pacific Islander, and American Indian/Alaska Native women in all counties where those populations, in aggregate, comprise at least seven percent of the adult female population.
Priority: Reduce cost, accessibility, and misinformation as barriers to breast cancer care for uninsured, underinsured, linguistically isolated, foreign-born or other medically underserved individuals in Front Range counties.	
Objective 1	By 2020, increase the requirement for organizations that receive screening/diagnostic grants to ensure 50 percent of individuals served are rarely/never screened women, an increase from a baseline of 35 percent of individuals served.
Objective 2	By May 2016, evaluate the Affiliate's community grant categories to assess whether applicants that provide screening, diagnostic and treatment services should be able to apply for a medical continuum of care grant rather than being required to apply for multiple direct service grants.
Objective 3	By June 2016, engage breast health care providers, WWC, and other key stakeholders in Colorado health statistics regions (HSRs) 2 and 18; HSRs 3, 14 & 15; and HSRs 16 and 21; to evaluate perceived value of securing regional mobile mammography units to increase screenings among women living in medically underserved areas in Front Range counties.
Objective 4	By April 2016, evaluate capacity to provide breast health education, health insurance literacy, and "what to ask your provider" materials, in patients' preferred languages, to all community and federally qualified health centers, imaging facilities, and cancer treatment facilities in the Affiliate service area.
Objective 5	By March 2016, partner with Denver-Metro, Larimer, Weld, and Boulder/Broomfield regional Komen coalitions to identify region-specific breast cancer barriers and develop collaborative strategy for resolution by 2020.

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

Introduction

Affiliate History

Susan G. Komen® Colorado was formed in December 2013 as a result of a merger between the Komen Denver, founded in 1992, and Komen Aspen, founded in 1991. Both Affiliates were established and managed for many years by dedicated volunteers from the community. Volunteers continue to be a strong and critical component of the Affiliate and serve in leadership, fundraising, administrative and roles.

The Affiliate has been the recipient of numerous awards including Susan G. Komen Outstanding Volunteer Award (2003); Education Outreach Honor Roll (2005 & 2009); State Policy Collaborative of the Year (2007); and Inaugural Promise Award (2010). The Affiliate received the 2012 Telly Award for its education video.

Komen Colorado serves a 22-county area in Colorado including Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Eagle, Garfield, Gilpin, Jefferson, Larimer, Logan, Morgan, Park, Phillips, Pitkin, Sedgwick, Summit, Washington, Weld and Yuma Counties.

Through 2015, Komen Colorado has invested \$41 million into local community-based organizations for breast cancer education, screening, treatment and support programs in its service area and raised an additional \$14 million for national breast cancer research. Prior to the merger in 2013, Komen Aspen funded 29 community-based organizations providing education, screening, diagnostic and treatment support services. Komen Denver funded 89 community-based organizations. Komen Colorado's local grants have provided Coloradans with more than:

- 29,500 clinical breast exams;
- 45,700 mammograms;
- 19,000 diagnostic tests diagnosing 540 breast cancers; and
- 1,500 treatment services (surgery, chemotherapy, radiation).

Representatives from Komen Colorado serve on the 2015 – 2020 Colorado Cancer Plan Steering Committee, Colorado Cancer Coalition and Colorado Breast Cancer Task Force. The Affiliate is a member of the Colorado Consumer Health Initiative and the Colorado Chronic Care Collaborative, which leverage the experiences of patients and consumers living with chronic health conditions to increase equitable access to quality health care. The Affiliate created a regional coalition model designed to increase collaboration between grant recipients and community-based organizations and to facilitate patients' progression through the breast cancer continuum of care – especially as patients are required to access services through multiple health care facilities and systems. This model has been replicated throughout the Komen Affiliate Network. As of 2014, Komen Colorado facilitated eight regional coalitions across its 22 counties.

Affiliate Organizational Structure

Komen Colorado is governed by a 15-member board of directors as of 2014. The board of directors can have as many as 21 members. The board officers include the board president,

president-elect, treasurer, deputy treasurer, vice president of mission initiatives and vice president of fund development. The board provides governance, strategic direction and fiduciary oversight for the Affiliate. Board Committees include: executive, finance, fund development, mission initiatives and inclusion. There are five additional board advisory members who provide expertise in the areas of medical, legal, and fund development. The advisory members do not have voting privilege.

As of 2015, Komen Colorado has nine full-time and two part-time staff who manage day-to-day operations for the Affiliate. The staff include: chief executive officer, director of development and marketing, director of mission programs, director of finance and operations, events manager, development manager, development coordinator, two mission coordinators, marketing and public relations coordinator, and accounting clerk.

The Affiliate works closely with local universities and colleges to recruit interns throughout the year and partners with AARP, which provides a part-time employee through that organization's job training program. The staff manage the operational committees which include: Race for the Cure[®], Pink Tie Affair[™], Ski Day, Ride for the Cure[™], public policy, education and grant review committees. The Affiliate has over 200 active volunteers throughout the year with an additional 1,200 volunteers who support Affiliate events.

The event committee volunteers help with logistics and fundraising for each event. The education volunteers provide breast health education, linkage to resources, and volunteer recruitment throughout the year. The public policy volunteers assist with legislative advocacy and education of elected officials. The grant review panel is responsible for reviewing grant applications.

Affiliate Service Area

According to 2013 US Census data, Komen Colorado's service area consists of 29,248 square miles with a population of 3,797,878 people, which represents 72 percent of the total population residing in Colorado (Figure 1.1). Of these individuals, 25.6 percent have incomes at or below 250 percent of the federal poverty level (see Appendix A. 2014 Federal Poverty Levels for incomes associated with poverty levels), 14.8 percent have no insurance and 10 percent have less than a high school education. Eleven percent of the population is foreign born, and 4.3 percent of the population is considered to be linguistically isolated. Females represent 46 percent of the population, with 89 percent identifying as White, five percent Black/African-American, 1.6 percent American Indian/Alaskan Native, and 4.2 percent Asian/Pacific Islander.

Komen Colorado's service area consists of urban and rural communities with the majority of people living in the Front Range counties of Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer and Weld Counties. The six-county northeast region is rural, with an average of 7.6 people per square mile compared to 762 people per square mile in the Front Range counties. The mountain and resort communities located throughout a seven-county area have a relatively small population year-round but experience large influxes of tourists in the summer and winter seasons.

KOMEN COLORADO SERVICE AREA

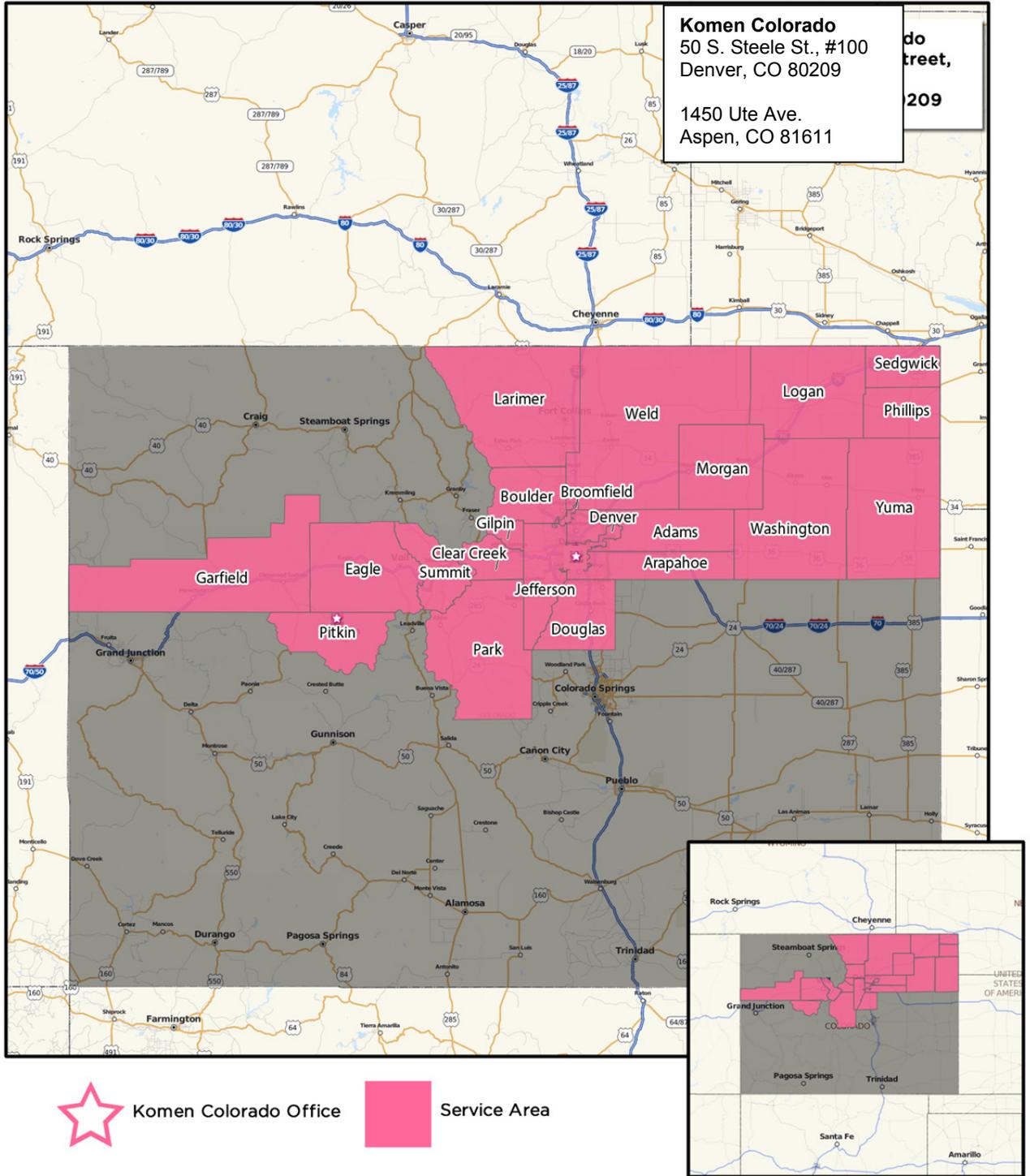


Figure 1.1. Susan G. Komen Colorado service area

Purpose of the Community Profile Report

The Community Profile is an assessment of breast cancer needs in Komen Colorado's 22-county service area. The Community Profile is used to identify populations most at risk for dying from breast cancer and their characteristics; identify needs and gaps in the health care system; identify community assets; and better understand what people know, think and do about breast cancer. The Community Profile is the foundation for strategic and operational planning and informs the Affiliate's priorities for mission and non-mission work. By focusing on these priorities, Komen Colorado can ensure that resources and programs reach the individuals most impacted by breast cancer.

The Community Profile will be used to inform the Affiliate's:

- Grant priorities;
- Education and outreach efforts;
- Advocacy and public policy initiatives;
- Inclusion efforts;
- Community engagement;
- Sponsorship and revenue-development efforts; and
- Marketing and communication plans.

Komen Colorado will share the Community Profile with its current and former grant recipients; regional coalitions; health care networks providing breast care within the service area; news media; donors and supporters; city, state and federal elected officials; and the broader community. The Affiliate will use social media, the Affiliate e-newsletter, and one-on-one and group meetings to distribute the Community Profile to a wide audience.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

Quantitative Data Report

Introduction

The purpose of the quantitative data report for Susan G. Komen® Colorado 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.

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

Breast Cancer Statistics

Incidence rates

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

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

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

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

- A negative value means that the rates are getting lower.
- A positive value means that the rates are getting higher.
- A positive value (rates getting higher) may seem undesirable—and it generally is. However, it's important to remember that an increase in breast cancer incidence could also mean that more breast cancers are being found because more women are getting

mammograms. So higher rates don't necessarily mean that there has been an increase in the occurrence of breast cancer.

Death rates

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

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

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

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

Late-stage incidence rates

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

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

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

Population Group	Incidence Rates and Trends				Death Rates and Trends			Late-stage Rates and Trends		
	Female Population (Annual Average)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of Deaths (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)	# of New Cases (Annual Average)	Age-adjusted Rate/ 100,000	Trend (Annual Percent Change)
US	154,540,194	198,602	122.1	-0.2%	40,736	22.6	-1.9%	70,218	43.7	-1.2%
HP2020	.	-	-	-	-	20.6*	-	-	41.0*	-
Colorado	2,437,011	3,203	125.3	0.9%	495	19.6	-2.3%	1,089	42.5	1.2%
Komen Colorado Service Area	1,744,143	2,238	126.8	0.7%	337	19.5	NA	765	42.9	2.0%
White	1,564,255	2,071	127.4	0.5%	315	19.7	NA	702	42.9	0.7%
Black/African-American	84,964	82	121.5	1.4%	15	25.3	NA	39	57.2	8.9%
American Indian/Alaska Native (AIAN)	26,001	9	47.9	34.6%	3	19.7	NA	SN	SN	SN
Asian Pacific Islander (API)	68,923	38	64.4	9.9%	4	7.8	NA	14	22.8	27.6%
Non-Hispanic/Latina	1,390,082	2,033	130.8	0.4%	310	20.0	NA	681	43.7	1.8%
Hispanic/Latina	354,061	205	95.6	6.6%	27	13.7	NA	84	37.3	5.9%
Adams County - CO	211,173	220	118.4	0.5%	31	17.3	3.3%*	78	41.3	10.4%
Arapahoe County - CO	281,745	365	127.4	2.2%	50	18.0	-2.6%	125	43.2	2.6%
Boulder County - CO	144,402	199	136.3	-0.1%	31	22.2	-2.6%*	65	43.4	-2.2%
Broomfield County - CO	26,610	30	107.4	-3.7%	6	24.7	NA	12	42.4	4.8%
Clear Creek County - CO	4,335	7	142.0	6.0%	SN	SN	SN	SN	SN	SN
Denver County - CO	288,740	381	133.2	1.5%	64	21.2	4.4%	132	46.6	5.2%
Douglas County - CO	137,965	166	135.2	3.0%	18	18.0	-2.0%	57	42.7	6.9%
Eagle County - CO	23,642	24	117.1	-3.5%	SN	SN	SN	7	34.6	0.9%
Garfield County - CO	26,456	32	130.2	-0.4%	5	22.9	-3.0%	12	44.0	17.3%
Gilpin County - CO	2,432	3	140.0	20.5%	SN	SN	SN	SN	SN	SN
Jefferson County - CO	266,401	416	131.4	-1.1%	61	19.4	-1.1%*	139	43.9	-4.8%
Larimer County - CO	146,667	194	126.1	2.0%	30	19.3	-1.7%	65	42.3	2.6%
Logan County - CO	9,753	13	109.2	9.0%	SN	SN	SN	4	34.3	NA
Morgan County - CO	14,081	15	95.6	5.5%	3	19.8	-3.6%	6	41.3	-1.6%
Park County - CO	7,758	11	112.4	12.2%	SN	SN	SN	4	38.4	-6.5%
Phillips County - CO	2,260	SN	SN	SN	SN	SN	SN	SN	SN	SN
Pitkin County - CO	7,710	10	100.5	-6.4%	SN	SN	SN	SN	SN	SN
Sedgwick County - CO	1,236	SN	SN	SN	SN	SN	SN	SN	SN	SN
Summit County - CO	12,149	13	94.8	-10.1%	SN	SN	SN	5	33.3	-12.8%
Washington County - CO	2,379	4	117.2	7.4%	SN	SN	SN	SN	SN	SN
Weld County - CO	121,260	122	107.5	0.3%	26	23.0	11.0%*	44	38.4	-0.7%
Yuma County - CO	4,989	7	112.9	-11.0%	SN	SN	SN	SN	SN	SN

*Target as of the writing of this report.

NA – data not available

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

Data are for years 2006-2010.

Rates are in cases or deaths per 100,000.

Age-adjusted rates are adjusted to the 2000 US standard population.

Source of incidence and late-stage data: North American Association of Central Cancer Registries (NAACCR) – Cancer in North America (CINA) Deluxe Analytic File.

Source of death rate data: Centers for Disease Control and Prevention (CDC) – National Center for Health Statistics (NCHS) mortality data in SEER*Stat.

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

*Source of death trend data: Colorado Central Cancer Registry.

Incidence rates and trends summary

Overall, the breast cancer incidence rate in the Komen Colorado service area was slightly higher than that observed in the US as a whole and the incidence trend was higher than the US as a whole. The incidence rate and trend of the Affiliate service area were not significantly different than that observed for the State of Colorado.

For the United States, breast cancer incidence in Blacks/African-Americans is lower than in Whites overall. The most recent estimated breast cancer incidence rates for Asians and Pacific Islanders (APIs) and American Indians and Alaska Natives (AIANs) were lower than for Non-Hispanic Whites and Blacks/African-Americans. The most recent estimated incidence rates for Hispanics/Latinas were lower than for Non-Hispanic Whites and Blacks/African-Americans. For the Affiliate service area as a whole, the incidence rate was lower among Blacks/African-Americans than Whites, lower among APIs than Whites, and lower among AIANs than Whites. The incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

The incidence rate was significantly lower in the following counties:

- Morgan County
- Weld County

The rest of the counties had incidence rates and trends that were not significantly different than the Affiliate service area as a whole, though there were not enough data available for some counties.

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

Death rates and trends summary

Overall, the breast cancer death rate in the Komen Colorado service area was lower than that observed in the US as a whole and the death rate trend was not available for comparison with the US as a whole. The death rate of the Affiliate service area was not significantly different than that observed for the State of Colorado.

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, lower among APIs than Whites, and about the same among AIANs than Whites. The death rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

None of the counties in the Affiliate service area had substantially different death rates than the Affiliate service area as a whole, though there were not enough data available for some counties.

Late-stage incidence rates and trends summary

Overall, the breast cancer late-stage incidence rate in the Komen Colorado service area was similar to 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 Colorado.

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

None of the counties in the Affiliate service area had substantially different late-stage incidence rates than the Affiliate service area as a whole, though there were not enough data available for some counties.

Mammography Screening

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

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

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

*As of October 2015

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

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

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

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

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

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

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

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

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

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	Confidence Interval of Proportion Screened
US	174,796	133,399	77.5%	77.2%-77.7%
Colorado	4,169	2,943	71.9%	70.1%-73.6%
Komen Colorado Service Area	2,174	1,591	73.2%	70.8%-75.4%
White	1,998	1,467	73.4%	71.0%-75.7%
Black/African-American	51	38	76.8%	61.2%-87.5%
AIAN	22	12	55.0%	30.0%-77.8%
API	25	21	74.5%	51.1%-89.1%
Hispanic/ Latina	168	109	65.3%	55.1%-74.2%
Non-Hispanic/ Latina	1,999	1,478	74.2%	71.8%-76.4%
Adams County - CO	262	185	67.5%	59.7%-74.5%
Arapahoe County - CO	247	191	75.7%	68.6%-81.7%
Boulder County - CO	177	119	68.0%	59.4%-75.5%
Broomfield County - CO	32	25	78.1%	57.5%-90.4%
Clear Creek County - CO	SN	SN	SN	SN
Denver County - CO	267	203	74.7%	67.7%-80.6%
Douglas County - CO	152	123	81.3%	72.5%-87.8%
Eagle County - CO	43	31	72.4%	53.4%-85.7%
Garfield County - CO	60	33	46.9%	31.4%-63.1%
Gilpin County - CO	SN	SN	SN	SN
Jefferson County - CO	361	272	75.9%	70.3%-80.7%
Larimer County - CO	214	158	74.7%	67.0%-81.2%
Logan County - CO	52	38	72.9%	56.6%-84.7%
Morgan County - CO	51	29	51.3%	33.7%-68.5%
Park County - CO	49	31	63.2%	44.2%-78.9%
Phillips County - CO	SN	SN	SN	SN
Pitkin County - CO	21	19	87.7%	65.4%-96.4%
Sedgwick County - CO	SN	SN	SN	SN
Summit County - CO	36	28	74.6%	54.4%-87.9%
Washington County - CO	SN	SN	SN	SN
Weld County - CO	150	106	71.2%	60.8%-79.7%
Yuma County - CO	SN	SN	SN	SN

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

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

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

- Garfield County
- Morgan County

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

Population Characteristics

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

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

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

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

Table 2.4. Population characteristics – demographics

Population Group	White	Black/ African- American	AIAN	API	Non- Hispanic /Latina	Hispanic /Latina	Female Age 40 Plus	Female Age 50 Plus	Female Age 65 Plus
US	78.8 %	14.1 %	1.4 %	5.8 %	83.8 %	16.2 %	48.3 %	34.5 %	14.8 %
Colorado	89.7 %	4.7 %	1.9 %	3.7 %	79.4 %	20.6 %	46.3 %	32.5 %	12.5 %
Komen Colorado Service Area	89.2 %	5.0 %	1.6 %	4.2 %	78.8 %	21.2 %	45.2 %	31.2 %	11.7 %
Adams County - CO	89.2 %	3.8 %	2.5 %	4.5 %	62.5 %	37.5 %	39.8 %	26.2 %	9.7 %
Arapahoe County - CO	80.9 %	11.4 %	1.4 %	6.4 %	81.8 %	18.2 %	45.9 %	31.6 %	11.6 %
Boulder County - CO	92.5 %	1.3 %	1.1 %	5.1 %	86.4 %	13.6 %	46.2 %	32.0 %	11.7 %
Broomfield County - CO	90.2 %	1.7 %	1.0 %	7.0 %	88.6 %	11.4 %	45.6 %	30.3 %	11.9 %
Clear Creek County - CO	96.9 %	1.0 %	1.3 %	0.8 %	94.6 %	5.4 %	62.3 %	44.8 %	13.5 %
Denver County - CO	81.7 %	11.3 %	2.5 %	4.4 %	68.8 %	31.2 %	40.5 %	28.5 %	11.9 %
Douglas County - CO	92.9 %	1.6 %	0.6 %	4.8 %	92.1 %	7.9 %	45.7 %	27.3 %	8.1 %
Eagle County - CO	96.1 %	1.0 %	1.4 %	1.4 %	69.6 %	30.4 %	41.2 %	24.9 %	6.3 %
Garfield County - CO	95.4 %	1.3 %	2.1 %	1.2 %	72.3 %	27.7 %	43.4 %	29.3 %	9.8 %
Gilpin County - CO	96.1 %	1.1 %	1.1 %	1.8 %	93.9 %	6.1 %	59.3 %	41.9 %	10.2 %
Jefferson County - CO	93.7 %	1.4 %	1.4 %	3.5 %	85.4 %	14.6 %	53.1 %	38.1 %	14.6 %
Larimer County - CO	94.9 %	1.3 %	1.2 %	2.6 %	89.4 %	10.6 %	46.3 %	33.9 %	13.6 %
Logan County - CO	96.8 %	1.3 %	1.1 %	0.8 %	87.9 %	12.1 %	52.3 %	40.4 %	19.4 %
Morgan County - CO	94.5 %	3.1 %	1.5 %	0.9 %	66.5 %	33.5 %	46.4 %	34.2 %	16.1 %
Park County - CO	96.6 %	1.1 %	1.4 %	1.0 %	94.9 %	5.1 %	63.4 %	46.0 %	12.4 %
Phillips County - CO	97.2 %	0.9 %	1.0 %	0.9 %	82.3 %	17.7 %	55.0 %	43.2 %	23.0 %
Pitkin County - CO	96.8 %	1.0 %	0.3 %	1.9 %	90.9 %	9.1 %	54.7 %	38.7 %	12.3 %
Sedgwick County - CO	97.2 %	1.1 %	0.6 %	1.1 %	88.4 %	11.6 %	61.5 %	50.7 %	26.7 %
Summit County - CO	96.9 %	1.0 %	0.8 %	1.3 %	85.4 %	14.6 %	46.3 %	30.9 %	8.6 %
Washington County - CO	98.5 %	0.7 %	0.3 %	0.6 %	91.8 %	8.2 %	57.5 %	45.1 %	21.6 %
Weld County - CO	95.1 %	1.4 %	1.7 %	1.8 %	72.1 %	27.9 %	41.8 %	28.7 %	10.8 %
Yuma County - CO	98.0 %	0.6 %	0.8 %	0.6 %	79.2 %	20.8 %	49.6 %	37.3 %	17.8 %

Data are for 2011.

Data are in the percentage of women in the population.

Source: US Census Bureau – Population Estimates

Table 2.5. Population characteristics – socioeconomics

Population Group	Less than HS Education	Income Below 100% Poverty	Income Below 250% Poverty (Age: 40-64)	Un-employed	Foreign Born	Linguistically Isolated	In Rural Areas	In Medically Under-served Areas	No Health Insurance (Age: 40-64)
US	14.6 %	14.3 %	33.3 %	8.7 %	12.8 %	4.7 %	19.3 %	23.3 %	16.6 %
Colorado	10.3 %	12.5 %	27.4 %	7.6 %	9.7 %	3.7 %	13.8 %	13.1 %	15.3 %
Komen Colorado Service Area	10.5 %	12.3 %	25.6 %	7.4 %	11.4 %	4.3 %	8.5 %	10.8 %	14.8 %
Adams County - CO	18.5 %	14.0 %	33.0 %	9.1 %	15.0 %	7.1 %	3.6 %	1.0 %	19.1 %
Arapahoe County - CO	9.4 %	11.9 %	24.6 %	7.4 %	14.9 %	5.7 %	1.6 %	0.9 %	14.4 %
Boulder County - CO	6.3 %	13.1 %	20.0 %	6.7 %	11.2 %	3.4 %	8.9 %	11.1 %	12.9 %
Broomfield County - CO	5.1 %	5.7 %	15.2 %	6.5 %	8.3 %	1.7 %	0.6 %	0.0 %	9.2 %
Clear Creek County - CO	3.5 %	6.1 %	22.2 %	6.0 %	3.5 %	0.0 %	100.0 %	100.0 %	12.2 %
Denver County - CO	15.3 %	18.8 %	38.0 %	8.3 %	16.4 %	7.1 %	0.0 %	42.8 %	18.7 %
Douglas County - CO	2.5 %	3.5 %	9.8 %	5.1 %	6.0 %	1.3 %	10.3 %	0.0 %	7.4 %
Eagle County - CO	12.2 %	10.3 %	25.5 %	5.2 %	19.7 %	9.1 %	20.0 %	0.0 %	17.9 %
Garfield County - CO	14.7 %	10.5 %	26.5 %	6.7 %	15.5 %	5.2 %	24.1 %	0.0 %	19.9 %
Gilpin County - CO	5.9 %	9.8 %	22.5 %	4.5 %	2.6 %	0.3 %	100.0 %	100.0 %	8.4 %
Jefferson County - CO	6.8 %	8.5 %	20.3 %	7.2 %	6.1 %	1.6 %	6.9 %	0.0 %	12.3 %
Larimer County - CO	6.1 %	13.4 %	23.9 %	7.9 %	5.4 %	1.4 %	11.7 %	0.0 %	14.0 %
Logan County - CO	12.5 %	15.0 %	35.9 %	8.1 %	5.6 %	2.6 %	29.2 %	0.0 %	17.5 %
Morgan County - CO	21.9 %	14.9 %	41.0 %	8.0 %	13.6 %	6.1 %	32.5 %	0.0 %	21.7 %
Park County - CO	5.2 %	6.5 %	24.4 %	7.2 %	2.3 %	0.1 %	100.0 %	0.0 %	16.7 %
Phillips County - CO	14.2 %	12.0 %	36.4 %	4.8 %	10.7 %	4.1 %	100.0 %	0.0 %	20.0 %
Pitkin County - CO	4.5 %	9.6 %	17.6 %	4.7 %	11.3 %	1.3 %	44.2 %	0.0 %	13.5 %
Sedgwick County - CO	14.8 %	14.9 %	40.9 %	7.0 %	2.4 %	1.1 %	100.0 %	0.0 %	19.9 %
Summit County - CO	5.3 %	10.1 %	22.1 %	6.3 %	12.6 %	3.4 %	19.5 %	0.0 %	15.5 %
Washington County - CO	13.0 %	11.8 %	38.1 %	2.6 %	4.0 %	2.4 %	100.0 %	100.0 %	20.6 %
Weld County - CO	14.8 %	13.8 %	31.0 %	6.7 %	9.0 %	3.8 %	20.5 %	23.3 %	17.3 %
Yuma County - CO	13.6 %	8.0 %	37.2 %	3.3 %	11.0 %	5.5 %	64.9 %	100.0 %	21.8 %

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

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

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

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

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

Population characteristics summary

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

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

- Arapahoe County
- Denver County

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

- Adams County
- Denver County
- Eagle County
- Garfield County
- Morgan County
- Weld County

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

- Logan County
- Phillips County
- Sedgwick County
- Washington County

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

- Adams County
- Morgan County

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

- Denver County

The county with substantial foreign born and linguistically isolated populations is:

- Eagle County

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

- Garfield County
- Morgan County
- Phillips County
- Sedgwick County
- Washington County
- Yuma 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 Colorado service area are progressing toward these targets, the report uses the following information:

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

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

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

Identification of priority areas

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

Late-stage incidence reflects both the overall breast cancer incidence rate in the population and the mammography screening coverage. The breast cancer death rate reflects the access to

care and the quality of care in the health care delivery area, as well as cancer stage at diagnosis.

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

Counties are classified as follows (Table 2.6):

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

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

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

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

Affiliate Service Area Healthy People 2020 Forecasts and Priority Areas

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

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

Trends can change for a number of reasons, including:

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

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

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

County	Priority	Predicted Time to Achieve Death Rate Target	Predicted Time to Achieve Late-stage Incidence Target	Key Population Characteristics
Adams County - CO	Highest	13 years or longer	13 years or longer	%Hispanic/Latina, education
Broomfield County - CO	Highest	NA	13 years or longer	
Denver County - CO	Highest	13 years or longer	13 years or longer	%Black/African-American, %Hispanic/Latina, poverty, foreign, medically underserved
Garfield County - CO	Medium High	4 years	13 years or longer	%Hispanic/Latina, rural, insurance
Arapahoe County - CO	Medium	Currently meets target	13 years or longer	%Black/African-American
Douglas County - CO	Medium	Currently meets target	13 years or longer	
Larimer County - CO	Medium	Currently meets target	13 years or longer	
Weld County - CO	Medium	13 years or longer	Currently meets target	%Hispanic/Latina, rural, medically underserved
Boulder County - CO	Medium Low	3 years	3 years	
Jefferson County - CO	Low	Currently meets target	2 years	
Morgan County - CO	Low	Currently meets target	1 year	%Hispanic/Latina, education, rural, insurance
Eagle County - CO	Lowest	SN	Currently meets target	%Hispanic/Latina, foreign, language, rural
Park County - CO	Lowest	SN	Currently meets target	Rural
Summit County - CO	Lowest	SN	Currently meets target	Rural
Clear Creek County - CO	Undetermined	SN	SN	Rural, medically underserved
Gilpin County - CO	Undetermined	SN	SN	Rural, medically underserved
Logan County - CO	Undetermined	SN	SN	Older, rural
Phillips County - CO	Undetermined	SN	SN	Older, rural, insurance
Pitkin County - CO	Undetermined	SN	SN	Rural
Sedgwick County - CO	Undetermined	SN	SN	Older, rural, insurance
Washington County - CO	Undetermined	SN	SN	Older, rural, insurance, medically underserved
Yuma County - CO	Undetermined	SN	SN	Rural, insurance, medically underserved

NA – data not available.

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

Map of Intervention Priority Areas

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

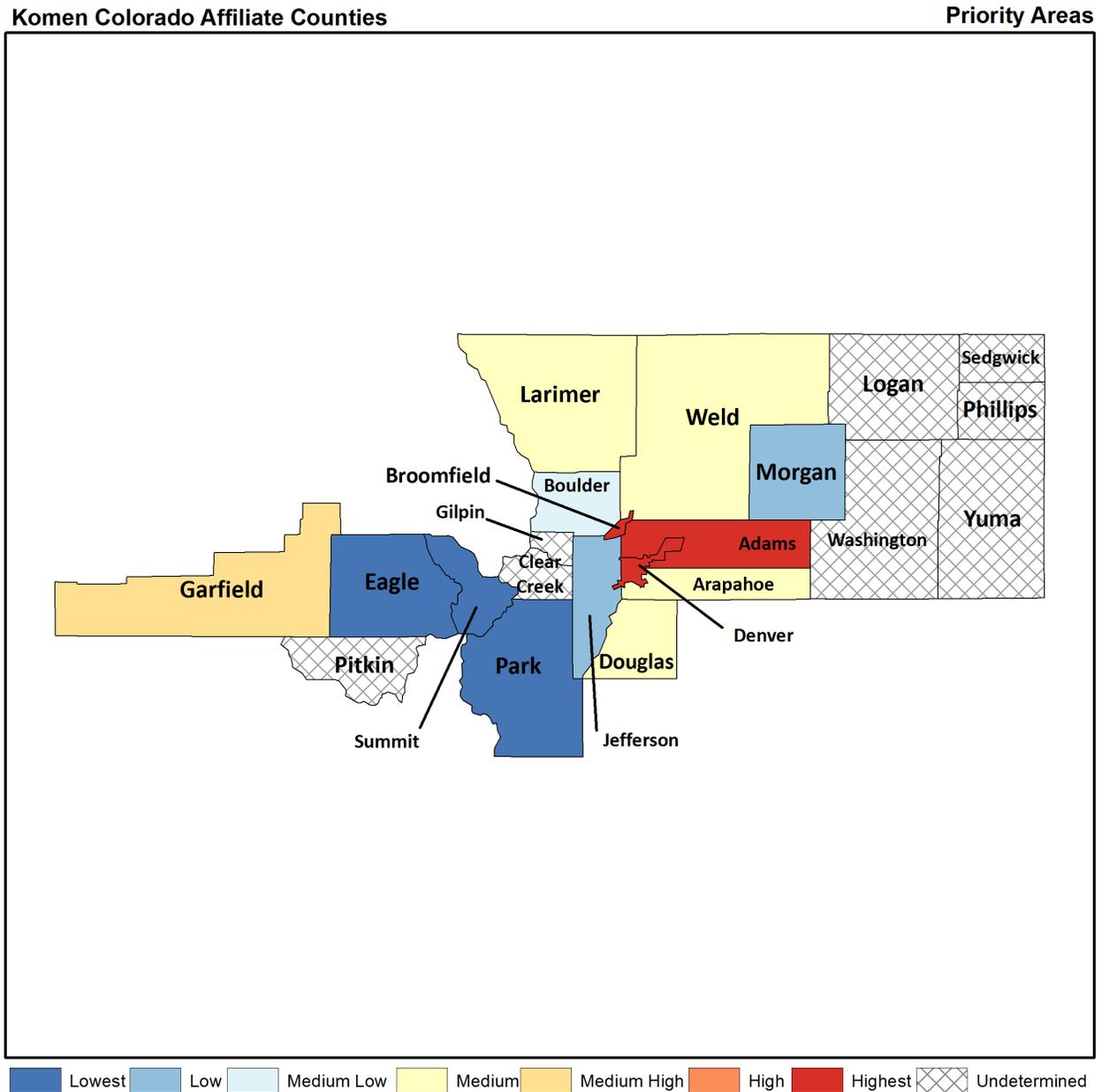


Figure 2.1. Intervention priorities

Data Limitations

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

- The most recent data available were used but, for cancer incidence and deaths, these data are still several years behind.
- For some areas, data might not be available or might be of varying quality.
- Areas with small populations might not have enough breast cancer cases or breast cancer deaths each year to support the generation of reliable statistics.

- There are often several sources of cancer statistics for a given population and geographic area; therefore, other sources of cancer data may result in minor differences in the values even in the same time period.
- Data on cancer rates for specific racial and ethnic subgroups such as Somali, Hmong, or Ethiopian are not 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 Colorado service area are in the highest priority category. Two of the three, Adams County and Denver County, are not likely to meet either the death rate or late-stage incidence rate HP2020 targets. One of the three, Broomfield County, is not likely to meet the late-stage incidence rate HP2020 target.

Adams County has a relatively large Hispanic/Latina population and low education levels. Denver County has a relatively large Black/African-American population, a relatively large Hispanic/Latina population, high poverty and a relatively large foreign-born population.

Medium high priority areas

One county in the Komen Colorado service area is in the medium high priority category. Garfield County is not likely to meet the late-stage incidence rate HP2020 target.

Screening percentages in Garfield County (47.0 percent) are significantly lower than the Affiliate service area as a whole (73.0 percent).

Garfield County has a relatively large Hispanic/Latina population.

Additional Quantitative Data Exploration

Komen Colorado collected additional data to supplement quantitative data about breast cancer incidence, stages of diagnoses, death rates, screening behaviors, demographic and socio-economic statistics provided by Susan G. Komen to assure adequate representation for counties within the Affiliate service area. The Affiliate also used analyses of Census Bureau findings, research into differences in costs of living between counties and Coloradans' attitudes about health insurance, and statistics provided by the Women's Wellness Connection (WWC), Colorado's National Breast and Cervical Cancer Early Detection Program, to inform its selection of target communities.

Much of the breast cancer data originally provided for rural counties was incomplete or missing when originally provided to the Affiliate. For example, because of their relatively small populations, individual rural counties reported numbers of breast cancer incidence, stage of

diagnoses, and deaths that were too few to calculate trends. The Affiliate requested the Colorado Cancer Registry provide breast cancer data in aggregate for Colorado Health Statistics Region 1, which is comprised of Logan, Morgan, Phillips, Sedgwick, Washington and Yuma Counties

Below is an overview of additional sources used by Komen Colorado, as well as limitations of those sources, to assist in identifying target communities in greatest need of Affiliate support:

Colorado Rural Health Center

The Colorado Rural Health Center, Colorado's nonprofit State Office of Rural Health, provides information about which counties have health care facilities designated as community safety net clinics, certified rural health clinics, and critical access and rural hospitals. The Affiliate used this information to understand the presence of health care facilities and health care service types in rural counties. However, the definitions of health facility types present in rural counties do not adequately reflect the scope of breast health care services available in Colorado's rural counties. As such, the Affiliate relies on this data to understand rural residents' ability to access primary preventive care, and to assess proximity to hospitals that can "triage" care for emergencies that may require stabilization and/or referral to specialty/acute care providers located in different counties. The Affiliate's prior experiences providing grants to pay for lodging and transportation for breast cancer patients who must travel for care inform the Affiliate's analysis of ongoing gaps in access to the full breast health continuum of care in rural counties in the Affiliate's service area.

Colorado Behavioral Risk Factor Surveillance System

The Colorado Behavioral Risk Factor Surveillance System (BRFSS) administered by the Health Statistics Section of the Colorado Department of Public Health and Environment collects data about participants' self-reporting of behaviors related to mammograms for women aged 40-74 via a phone-based survey. These data expand on the screening percentages for women aged 50-74 originally received by the Affiliate. Komen Colorado requested this data to understand screening behaviors among women beginning at age 40 - the age at which Susan G. Komen recommends women with an average risk for breast cancer begin annual screenings. Because BRFSS relies on self-reporting of health behaviors, women may not accurately recall the date of last screening. Moreover, women may over-report behavior that is socially perceived as "good" or "responsible," including screenings like mammograms.

Supplemental data from BRFSS found that only 68.5 percent of Colorado women between the ages of 40 and 74 and 69.1 percent of those within Komen Colorado's service area reported having had a mammogram within the last two years (Table 2.8). Among Colorado women aged 50-74, the percentages are 71.9 and 73.2, respectively. This compares to 77.5 percent of women aged 50-74 for the US as a whole (Table 2.3), and a goal of 81.1 percent by 2020 (US Department of Health and Human Services, 2014). Of Hispanic/Latina women in Komen Colorado's service area, only 59.2 percent of those between the ages of 40 and 74 report having had a mammogram in the last two years, and 65.8 percent of Black/African-American women report having had a mammogram (Table 2.8).

Table 2.8. Proportion of women ages 40-74 with screening mammography in the last two years, self-report

Population Group	# of Women Interviewed (Sample Size)	# w/ Self-Reported Mammogram	Proportion Screened (Weighted Average)	95% Confidence Interval of Proportion Screened
Colorado	4,313	2,991	68.5%	66.7%-70.3%
Komen Colorado Service Area	2,430	1,721	69.1%	66.9%-71.4%
White	2,225	1,589	70.1%	67.7%-72.4%
Black/African-American	69	47	65.8%	52.7%-78.9%
AIAN	28	15	52.0%	30.5%-73.5%
Asian	35	27	72.8%	55.7%-90.0%
Native Hawaiian or Other Pacific Islander	3	3	100.0%	100.0%
Hispanic/ Latina	234	137	59.2%	52.0%-63.4%
Non-Hispanic/ Latina	2,218	1,602	70.8%	68.5%-73.2%
Adams County	285	198	65.8%	59.1%-72.4%
Arapahoe County	277	209	71.2%	64.7%-77.6%
Boulder County	194	125	65.0%	57.3%-72.7%
Broomfield County	35	27	75.1%	57.3%-92.9%
Clear Creek County	16	13	87.0%	72.4%-100%
Denver County	290	216	70.5%	64.2%-76.8%
Douglas County	198	160	81.6%	75.3%-87.8%
Eagle County	55	40	77.1%	64.8%-89.4%
Garfield County	57	30	45.8%	30.7%-60.9%
Gilpin County	15	6	18.8%	0.7%-36.8%
Jefferson County	390	289	70.7%	65.2%-76.2%
Larimer County	222	158	69.3%	62.2%-76.4%
Logan County	47	30	60.7%	41.8%-79.6%
Morgan County	46	24	57.5%	37.4%-77.7%
Park County	55	31	55.6%	38.7%-72.4%
Phillips County	7	5	70.3%	32.01%-100%
Pitkin County	24	22	86.0%	68.2%-100%
Sedgwick County	7	3	24.5%	0.0%-55.9%
Summit County	38	30	73.0%	54.9%-91.0%
Washington County	8	5	72.3%	41.6%-100%
Weld County	171	109	62.5%	53.9%-71.1%
Yuma County	19	10	43.6%	15.6%-71.7%

Source: Colorado Department of Public Health and Environment, Health Statistics Section, Colorado Behavioral Risk Factor Surveillance Systems (BRFSS) 2012.

State Demography Office

The Demography Office of the Colorado Department of Local Affairs provides historic, current, and projected population estimates by county, statistical region, and municipality from historical Census and other data. Komen Colorado retrieved population forecasts for counties served by the Affiliate to project the number of women aged 40-64 that are anticipated to live in the service area through 2020. This will be the year through which the Affiliate will utilize this report to inform strategic direction of its grantmaking, public policy, education and other programming. These data give the Affiliate an understanding of total potential growth in demand for breast health care and possible shifts in populations across counties through 2020 (Table 2.9). One limitation of the data are that information could not be separated out by sub-populations/demographic characteristics that are correlated with disparities in overall breast health or breast cancer outcomes (i.e., un- or underinsured women, women of different ethnicities, women with lower educational attainment).

Table 2.9. Projected increase in population of women aged 40-64, 2010-2020

County	Women Aged 40-64		Difference 2010-2020	Percent Change 2010-2020
	2010	2020		
Adams	65,788	80,593	14,805	22.5%
Arapahoe	100,313	111,334	11,021	11.0%
Boulder	51,268	55,590	4,322	8.4%
Broomfield	9,795	12,120	2,325	23.7%
Denver	86,332	101,690	15,358	17.8%
Douglas	53,695	66,005	12,310	22.9%
Eagle	8,293	10,821	2,528	30.5%
Garfield	9,126	11,077	1,951	21.4%
Gilpin	1,276	1,198	-78	-6.1%
Jefferson	103,883	98,954	-4,929	-4.7%
Larimer	50,005	53,991	3,986	8.0%
Logan	3,148	3,140	-8	-0.3%
Morgan	4,335	4,756	421	9.7%
Park	3,873	3,705	-168	-4.3%
Phillips	705	687	-18	-2.6%
Pitkin	3,436	3,427	-9	-0.3%
Sedgwick	424	382	-42	-9.9%
Summit	4,698	5,637	939	20.0%
Washington	837	740	-97	-11.6%
Weld	39,013	47,449	8,436	21.6%
Yuma	1,602	1,612	10	0.6%
HSR 1	11,051	11,317	266	2.4%
Total	601,845	674,908	73,063	12.1%

Source: State Demography Office; population query by age and gender for individuals aged 40-64 for 2010, 2015 and 2020 living in counties within Komen Colorado service area.

American Community Survey

Analyses of the American Community Survey issued by the US Census Bureau carried out by various research institutes provide Komen Colorado with an understanding of segments of populations within the Affiliate's service area that are considered foreign-born. These data help the Affiliate understand characteristics of the projected population that will remain uninsured

after Medicaid expansion and enrollment in private marketplaces because of federal and state laws restricting certain foreign-born populations' access to both public and private health insurance options. Specifically, federal and state laws narrowly prescribe eligibility based on whether an individual is a citizen, has been a legal permanent resident for a specific length of time, holds a visa, or is otherwise undocumented (National Immigration Law Center, 2014). These laws determine eligibility for enrollment in WWC, Colorado's Medicaid Breast and Cervical Cancer Treatment Program (BCCP), regular Medicaid, Medicare, and the Colorado Indigent Care Program. In combination with subsidized private insurance plans purchased by individuals earning less than 250 percent of the federal poverty level through the state's insurance exchange, these publicly funded programs provide health insurance coverage/payment for clinical breast exams, mammograms, diagnostic work-ups, and for individuals diagnosed with breast cancer, treatment. Expanded eligibility for these programs relieves a portion of Komen Colorado's burden of covering these costs through its Community Grant program. Because of federal and state laws restricting adult enrollment in publicly funded health insurance or purchase of private plans through the state's insurance exchange, Komen Colorado's Community Grant program still acts as the primary source of payment for breast health care services for certain foreign-born women and men. However, county-level data of immigration status by age, gender and household income are unavailable, which limits the Affiliate's ability to determine, at a county-level basis, greatest need among some foreign-born populations.

Colorado Health Access Survey

The Colorado Health Access Survey (CHAS), a project of The Colorado Health Institute, is a multi-year, random-sample telephone survey that gathers data about Coloradans' health insurance coverage, utilization of health care, and attitudes about both insurance and the health care system. The survey has been conducted in 2009, 2011 and 2013, and provides comparative data about changes in insurance coverage, affordability and access to care by age, race/ethnicity, income, employment, and region of residency within the state. Komen Colorado used analyses of the 2013 CHAS to understand characteristics that contribute to disparities in health insurance coverage between Hispanic/Latino/a Coloradans and their non-Hispanic counterparts. Although CHAS asks questions about Coloradans' citizenship, it does not dive into respondents' immigration status (i.e., legal permanent residency, type of visa if in Colorado temporarily, etc.). This limits the Affiliate's ability to examine nuances in barriers to health care overall for certain populations that live within Komen Colorado's service area.

Women's Wellness Connection

Women's Wellness Connection penetration rates were used to understand disparities in screenings for breast and cervical cancer across counties among eligible women. The rates measure percentage of uninsured women aged 40-64 who were at or below 250 percent of the federal poverty level who were screened for breast and/or cervical cancer (Table 2.10). They are from Colorado fiscal year 2012-2013, which covers the 12 months ending June 30, 2013, and is the latest year for which data are available. This can be considered a lagging, rather than predictive, indicator of the program's success in increasing screening behaviors among certain medically underserved populations. The WWC program also calculates its penetration rates from a baseline universe of eligible Coloradans defined as total uninsured women aged 40-64 identified from the Small Area Health Insurance Estimates (SAHIE) provided by the US Census Bureau. SAHIE counts include all uninsured individuals, regardless of citizenship/documentation status, artificially increasing the potentially eligible populations because only citizens or individuals who have been legal permanent residents for at least five years are eligible for

WWC. SAHIE counts also include only uninsured individuals – although WWC eligibility extends to underinsured individuals.

Table 2.10. Percent of target population screened for breast and cervical cancer through Women’s Wellness Connection, Colorado Fiscal Year 2012-2013

Region / County in Komen Affiliate Service Area	Percent Screened	Total Eligible Population
Colorado*	22%	79,816
Adams	21%	7,808
Arapahoe	20%	8,610
Boulder	35%	3,629
Broomfield	18%	536
Clear Creek	22%	159
Denver	29%	10,753
Douglas	14%	2,053
Eagle	11%	942
Garfield	19%	1,070
Gilpin	47%	72
Jefferson	16%	7,327
Larimer	18%	4,241
Logan	16%	349
Morgan	7%	645
Park	12%	383
Phillips	7%	95
Pitkin	30%	244
Sedgwick	4%	53
Summit	31%	424
Washington	5%	106
Weld	18%	4,547
Yuma	11%	228

Source: Colorado Department of Public Health and Environment, Women’s Wellness Connection. Percent screened calculated by dividing the total number of WWC screens for breast and cervical cancer by the SAHIE county population estimate. Eligible population based on SAHIE population estimates for uninsured women age 40-64 who were at or below 250% of the federal poverty level in 2011.

* Colorado percentage calculated by total number of unduplicated women served by WWC in FY 2012-13 reported in the WWC Toolkit divided by the total estimated number of uninsured women under 250% FPL provided WWC according to figures pulled from the Small Area Health Insurance Estimates maintained by the US Census Bureau

Self-Sufficiency Standard for Colorado

The Self-Sufficiency Standard for Colorado is a multi-year report prepared for The Colorado Center on Law and Policy that estimates costs of living for 152 family types for each of Colorado’s 64 counties. The self-sufficiency standard is defined as the income required for a family to pay for basic living expenses without public or private assistance. Included in the county-based self-sufficiency calculations are local costs for housing, child care, food, transportation, health care costs, taxes, and certain miscellaneous expenses like diapers,

clothing, hygiene and household cleaning products, and telephone service. The standard considers the impact of applicable tax credits when appropriate. The report has been issued in 2001, 2008 and 2011 and provides long-term, comparative data about how costs of living have changed over time. Komen Colorado used the 2011 report to obtain information about variances in costs of living between counties within the Affiliate service area to understand how expenses for breast health and breast cancer care can have disproportionate impacts based on individuals' county of residence (Table 2.11).

Table 2.11. Estimated annual self-sufficiency levels in mountain and resort counties vs upper-income threshold for WWC, BCCP, Komen eligibility and percentage of population meeting income eligibility

Select Counties in Komen Colorado Service Area	% of 40-64 Year-Olds with Income Below 250% FPL*	1 Adult		1 Adult + 2 School-aged Children		2 Adults + 2 School-aged Children	
		Self-Sufficiency Standard	250% FPL (2011 Dollars)	Self-Sufficiency Standard	250% FPL (2011 Dollars)	Self-Sufficiency Standard	250% FPL (2011 Dollars)
Colorado	27.4%	NA	\$27,225	NA	\$46,325	NA	\$55,875
Adams	33.0%	\$23,144	\$27,225	\$47,499	\$46,325	\$54,684	\$55,875
Arapahoe	11.9%	\$22,936	\$27,225	\$46,896	\$46,325	\$54,018	\$55,875
Boulder	20.0%	\$24,527	\$27,225	\$51,064	\$46,325	\$58,370	\$55,875
Broomfield	15.2%	\$25,396	\$27,225	\$48,953	\$46,325	\$56,158	\$55,875
Clear Creek	22.2%	\$21,628	\$27,225	\$40,336	\$46,325	\$47,636	\$55,875
Denver	38.0%	\$19,296	\$27,225	\$41,084	\$46,325	\$46,388	\$55,875
Douglas	9.8%	\$27,631	\$27,225	\$55,395	\$46,325	\$62,706	\$55,875
Eagle	25.5%	\$27,433	\$27,225	\$51,758	\$46,325	\$58,643	\$55,875
Garfield	26.5%	\$27,566	\$27,225	\$46,979	\$46,325	\$54,007	\$55,875
Gilpin	22.5%	\$24,326	\$27,225	\$42,446	\$46,325	\$49,534	\$55,875
Jefferson	20.3%	\$23,295	\$27,225	\$47,546	\$46,325	\$54,668	\$55,875
Larimer	23.9%	\$20,808	\$27,225	\$43,581	\$46,325	\$50,327	\$55,875
Logan	35.9%	\$17,011	\$27,225	\$34,082	\$46,325	\$42,747	\$55,875
Morgan	41.0%	\$18,330	\$27,225	\$37,140	\$46,325	\$45,292	\$55,875
Park	24.4%	\$27,204	\$27,225	\$51,511	\$46,325	\$58,385	\$55,875
Phillips	36.4%	\$17,272	\$27,225	\$32,226	\$46,325	\$40,351	\$55,875
Pitkin	17.6%	\$27,177	\$27,225	\$51,299	\$46,325	\$57,149	\$55,875
Sedgwick	40.9%	\$17,301	\$27,225	\$37,242	\$46,325	\$45,356	\$55,875
Summit	22.1%	\$25,197	\$27,225	\$49,418	\$46,325	\$56,282	\$55,875
Washington	38.1%	\$17,352	\$27,225	\$29,762	\$46,325	\$37,861	\$55,875
Weld	31.0%	\$19,352	\$27,225	\$41,255	\$46,325	\$48,509	\$55,875
Yuma	37.2%	\$17,338	\$27,225	\$30,187	\$46,325	\$38,305	\$55,875

Sources: Diana Pearce for Colorado Center on Law and Policy, *Self-Sufficiency Standard for Colorado State 2011*, and Centers for Medicare & Medicaid Services, *250% Federal Poverty Guidelines for 2011*.

*FPL rates from Table 5.

Because the population that benefits from Komen Colorado's Community Grant program is uninsured or underinsured, one of the limitations of the data are that health care costs used to determine self-sufficiency levels are based on average premiums for individuals with employer-sponsored health insurance. Another limitation with this report is tied to Komen Colorado's lack

of data about the typical household composition of individuals who benefit from Community Grant funds (i.e., number of adults and ages of any children in the household). For purposes of this Community Profile, Komen Colorado selected self-sufficiency rates for households comprised of one adult, one adult with two school-aged children (younger than teen-aged years but not in need of child care), and two adults with two school-aged children. Another limitation in use of this data are that self-sufficiency standards are calculated for families without special needs such as long-term care for dependent adults or health-care costs to manage chronic conditions. Finally, the report does not calculate self-sufficiency levels for the state as a whole.

Disclaimer: Selection of target communities based on data and reports available at the time of writing in 2014. More recent data and reports have been released for breast cancer incidence, mortality, and stages of diagnosis (Colorado Central Cancer Registry); screening rates (BRFSS); Women’s Wellness Connection assessments of eligible-to-screened figures; health care access and utilization (CHAS); and the Colorado self-sufficiency standard. Notes of more recent data indicated in Reference section.

Selection of Target Communities

Because Komen Colorado’s service area covers 72 percent of the state’s population, positive changes in breast health care decision-making behaviors, diagnosis of breast cancer in early stages, and increased survivorship rates within the Komen Colorado service area will substantively affect the state’s capacity to meet the breast health targets established by Healthy People 2020 (HP2020). Overall, the breast cancer incidence rate in Komen Colorado’s service area was slightly higher than that observed in the US as a whole for 2006-2010 and the incidence trend was higher than the US as a whole during that same timeframe. The incidence and trend rate were not significantly different than that observed for the State of Colorado. An increased incidence rate could mean that breast cancers are being found because women are getting more mammograms.

Komen Colorado examined the quantitative data regarding female breast cancer incidence, stages of diagnoses, death rates, demographic information, and socioeconomic indicators that have been tied to adverse breast health outcomes, as well as supplementary data and research findings from the previously mentioned sources, to identify four target communities. The Affiliate will focus its grantmaking, public policy, public education and outreach, and other programming efforts for the next four years in these communities. Based on this review, Komen Colorado has selected the following four target communities:

- Hispanic/Latina Women
- Rural northeast Colorado (Colorado Health Statistics Region 1)
- Mountain and resort towns
- Medically Underserved Communities within Front Range counties

Discussion of the factors that contributed to the selection of each community is provided below.

It is important to note that breast cancer incidence, diagnoses, death and screening data were not available for populations known by the Affiliate through anecdotal reporting from its Community Grant program to be medically underserved. This population includes asylum seekers, refugees, visa-holding temporary residents, individuals with fewer than five years of legal permanent residency status, and otherwise undocumented individuals; and lesbian, gay,

bisexual and transgender individuals. In addition to the qualitative research specified for each of the target communities identified below, Komen Colorado also will explore these communities in more depth to determine additional unmet needs or barriers to breast health care/specific to these populations. The overall lack of demographic-specific breast cancer data for these populations is an area for future research and analysis.

Hispanic/Latina Women

Komen Colorado has selected Hispanic/Latina women as a target community because of lower screening percentages seen in these women compared to the Affiliate service area as a whole, as well as the presence of social determinants of health that adversely affect their breast health outcomes. While the Hispanic/Latina population in the Affiliate's service area experiences lower age-adjusted rates for breast cancer incidence, death, and late-stage diagnoses compared to non-Hispanic/Latina populations (Table 2.1), the trend for late-stage diagnoses is increasing at 5.9 percent among Hispanic/Latina women compared to just 1.8 percent for non-Hispanic/Latina women.

Susan G. Komen reports that nationally, breast cancer is both the most common cancer among Hispanic/Latina women and the leading cause of cancer death among this population (as it is for non-Hispanic/Latina women). National research also has found that Hispanic/Latina women are "more likely to be diagnosed with larger tumors and tumors that are hormone receptor negative, both of which are more difficult to treat" (2011). With Hispanic/Latina populations comprising 21.2 percent of the Affiliate's service area – a percentage expected to increase through 2020 according to demographic forecasts – the Affiliate has identified this population as a target community.

Overall, only 59.2 percent of Hispanic/Latina women in the Affiliate service area between the ages of 40 and 74 report having had a mammogram in the last two years – far below the rate of 70.8 percent of non-Hispanic/Latina women and the overall rate of 69.1 percent of women within the service area in this same age range (Table 2.8). Among women aged 50-74 within the Affiliate's service area, the self-reported screening percentage for Hispanic/Latina women in the last two years was slightly higher at 65.3 percent, although that percentage is still lower than the non-Hispanic/Latina rate of 74.2 percent and 73.2 percent for the Affiliate service area overall (Table 2.3). Because early and regular screening has been demonstrated to increase detection of early stage breast cancer, these lower screening percentages among Hispanic/Latina women could contribute to disparities in late-stage diagnosis trends between Hispanic/Latina populations.

In addition to screening percentages, Komen Colorado used analyses of the Colorado Health Institute's (CHI) biannual Colorado Health Access Survey (CHAS) to assess differences in demographic indicators that may contribute to disparities in overall health outcomes between the state's Hispanic/Latino/a and non-Hispanic/Latino/a populations. According to CHI, 58.1 percent of Hispanic/Latino adults in Colorado "have annual family incomes at or below 200 percent of the federal poverty level (FPL) - about 20 percentage points more than non-Hispanics."

The 2013 CHAS also revealed a 14.5 percentage-point gap in health insurance coverage between Hispanic/Latino and non-Hispanic/Latino Coloradans; 31.0 percent of adult Hispanic/Latinos in Colorado reported they are uninsured compared to 16.5 percent of non-

Hispanic/Latino adults. According to Susan G. Komen, women who do not have health insurance are almost four times as likely to be diagnosed with advanced breast cancer compared to women with health insurance. Komen also reports that in 2010, less than one-third of uninsured women over 40 had a mammogram within the past two years compared to 71 percent of those with insurance. Because of this relationship between health insurance status and breast health outcomes, Komen Colorado has consistently supported efforts to increase the percentage of the state's – and the Affiliate's – population that has public or private health insurance that covers breast health care.

CHAS data reveal that nearly one-third of uninsured Hispanic/Latino Coloradans (30.7 percent) said they don't know how to get insurance, compared with 11.6 percent of non-Hispanic/Latino populations. CHI's analysis also determined citizenship status accounts for about 33 percent of the gap in health insurance coverage between Hispanic/Latino and non-Hispanic/Latino adults aged 19-64. Understanding factors that contribute to the coverage gap among a growing sector of the population served by Komen Colorado will enable the Affiliate to develop a multi-pronged strategy to work to close that gap. The Affiliate can develop targeted strategies in its Community Grant program, public policy priorities, and education/outreach to increase literacy about health insurance within the Hispanic/Latina population.

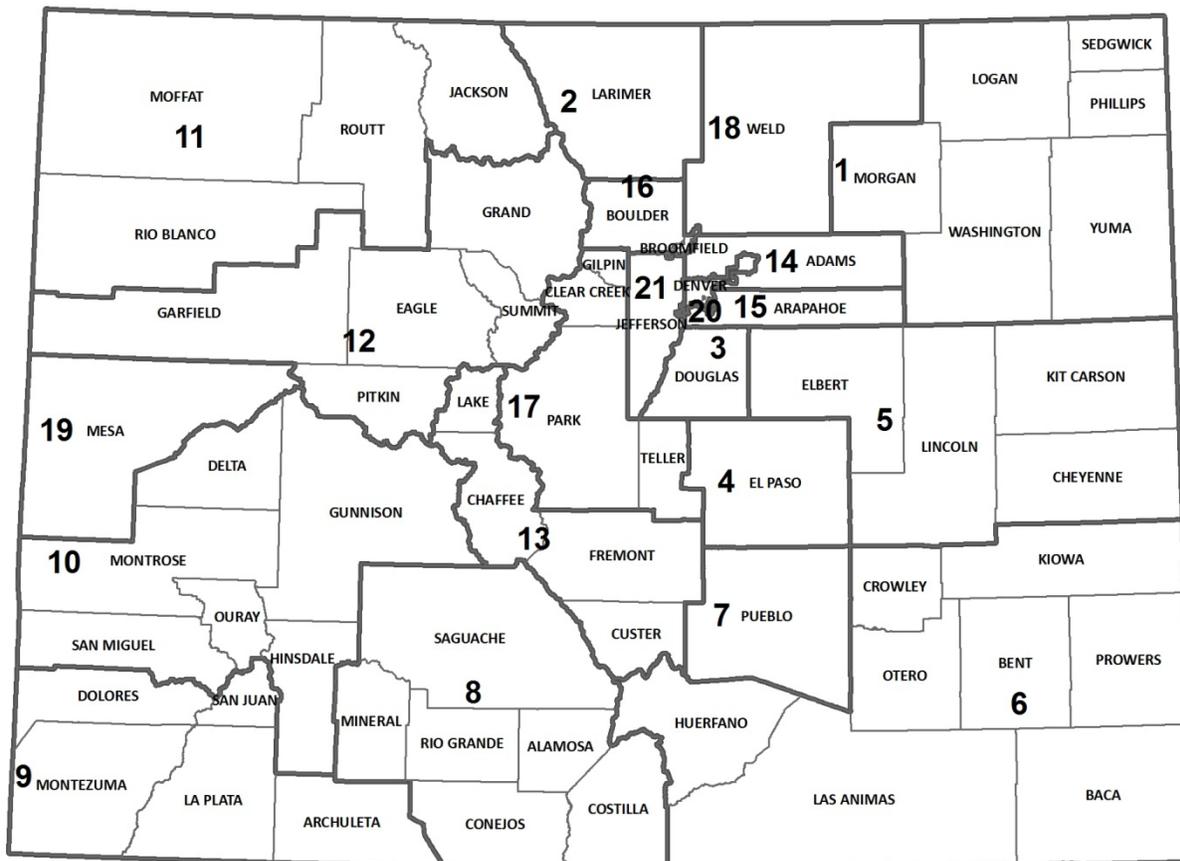
At this point it is important to note that Komen Colorado recognizes Hispanic/Latina ethnicity does not signify citizenship or documentation status. However, the CHI estimates that 22.3 percent of Hispanic/Latino adults in Colorado are not US citizens. Because Komen Colorado expects grant-receiving organizations to use Community Grant funding as the payment of last resort for breast health care services, the Affiliate seeks to better understand barriers to health insurance coverage for Hispanic/Latina communities overall. The relationship between documentation status and insurance coverage among Hispanic/Latina women within the Affiliate's service area is one issue that will be explored in the qualitative section of this report. For the Hispanic/Latina target community, the qualitative section also will examine whether, and to what extent, language is a barrier to health care, overall literacy about breast health and health insurance, and enrolling in or purchasing health insurance.

Rural Northeast Colorado

(Colorado Health Statistics Region 1: Logan, Morgan, Washington, Sedgwick, Phillips, and Yuma Counties)

Colorado Health Statistics Region 1 is a combination of six counties in northeastern Colorado developed by the Health Statistics Section of the Colorado Department of Public Health and Environment and state and local public health professionals (Figure 2.2).¹ The region includes Logan, Morgan, Phillips, Sedgwick, Washington and Yuma Counties. The region consists of small towns, ranches and livestock farms and is isolated and rural.

¹ There are 21 Colorado Health Statistics Regions that have been developed to support the Project TEACH (Teaching Equity to Advance Community Health) project to "promote health care and advance healthy living in Colorado" through the University of Colorado School of Public Health.



Source: Colorado Department of Public Health and Environment, Health Statistics Section.

Figure 2.2. Map of Colorado Health Statistics Regions

The rural northeast Region covers 9,300 square miles and has 7.8 people per square mile (US Census Bureau). As of 2010, the region had an estimated population of 11,051 women aged 40-64, a demographic projected to increase by 2.4 percent by 2020 (Table 2.9).

In this rural part of the state, there is limited access to medical facilities, which is exacerbated by economic barriers to care for low-income and uninsured individuals. Residents in these counties face the additional barrier of transportation because they must travel long distances to reach a medical facility. According to data from the Colorado Rural Health Center (2013), cancer patients from rural communities reportedly have to travel “six to 10 times farther for chemotherapy and two to four times farther for radiation therapy” than their urban counterparts. In addition, the Colorado Health Access Survey found HSR 1 had the highest percentage of uninsured Coloradans, with 22.7 percent of the region’s insured residents unable to meet co-pays, deductibles, and other patient responsibilities for their health care (2013). Due to the small population of these counties, much of the quantitative breast cancer trend data are not available by county.

Other considerations for making rural northeast Colorado/HSR 1 region a targeted community are that female breast cancer death rates overall are rising, WWC screening percentages are low, and when compared to the Affiliate service area, the counties in this region have an older female population, higher uninsured rates and higher poverty. Breast cancer data for each county, where available, will be discussed below. Within the region, HP2020 breast cancer targets indicate Morgan County to be a low priority. HP2020 breast cancer targets for Logan, Phillips, Sedgwick, Washington and Yuma Counties are undetermined because data are

suppressed due to small numbers. However, regional analysis by the Colorado Cancer Registry calculated the 5-year estimated annual percent change in female breast cancer deaths to be rising by 9.9 percent per year in this region. The rising death rate is concerning and more research is needed to determine how to reverse this trend.

Morgan County has a significantly lower incidence rate of breast cancer than the Affiliate service area as a whole, significantly lower screening mammography rates than the Affiliate service area as a whole and the death rate is falling. This county has a substantially larger Hispanic/Latina female population, substantially larger population below 250 percent of the federal poverty level, and substantially lower education levels compared to that of the Affiliate service area as a whole (Tables 2.4 and 2.5). Lower education and income levels correlate with lower screening percentages. Due to these factors that affect the screening percentage in this county, Komen Colorado includes Morgan County in its selection of rural northeast Colorado as a target community.

Other social determinants of health that have been linked with either higher breast cancer incidence or poorer breast cancer outcomes are common throughout the region. According to Tables 2.4 and 2.5, Logan, Phillips, Sedgwick, Washington and Yuma Counties have a substantially older female population and substantially larger population of 40- to 64-year olds below 250 percent of the federal poverty level than the Affiliate as a whole. Morgan, Phillips, Sedgwick, Washington and Yuma Counties have a substantially larger percentage of adults without health insurance than does the Affiliate service area as a whole. All counties have a lower screening percentage of eligible women through WWC, with Sedgwick screening only four percent of eligible women, Washington five percent, Morgan seven percent, Yuma 11 percent, and Logan 16 percent compared to the average screening percent of 21.4 percent eligible women throughout the state (Table 2.10).

As of May 2014, Sedgwick and Phillips have no WWC providers in the county and the remaining counties have one WWC program. Washington and Yuma are considered to be medically underserved areas according to the Health Resources and Services Administration (HRSA) for 2013. Phillips, Sedgwick, Washington and Yuma are considered rural areas (Table 2.5). Due to these factors that affect county residents' ability to access breast health care services and breast cancer specialists, Komen Colorado includes Logan, Phillips, Sedgwick, Washington and Yuma Counties in its selection of Northeast Colorado as a target community.

The health systems analysis component of this report will take a deeper look at the available breast health services in the region, specifically for programs that provide services to uninsured and low-income individuals.

Mountain and resort towns (Clear Creek, Park, Summit, Eagle, Garfield and Pitkin Counties)

Komen Colorado combines residents of counties that are home to mountain and resort towns throughout the Affiliate's service area into one target community because of common characteristics that inhibit residents' ability to access breast health care services and their shared dependence on one highway – Interstate 70 – to access necessary care. Like the counties of rural northeast Colorado, the counties are not densely populated, with 20.5 people per square mile. Instead, the counties are characterized by isolated mountain and resort towns, or sporadically developed residential communities in unincorporated parts of the counties that

depend on tourism for their economies. A tourism economy is based on the service industry, which results in wide discrepancies of income between the individuals who work in the service industry, the tourists that use the services provided - e.g., ski resorts, rafting/fishing guides, restaurants, and hotels – and those who own second homes in the communities.

The 2011 self-sufficiency figures calculated for the Colorado Center on Law and Policy emphasizes the impact of this gap (Pearce, 2011). Table 2.11 compares the estimated annual self-sufficiency standard for one-, three-, and four-person households in select counties in Komen Colorado's service area to the income-eligibility ceiling to enroll in WWC, BCCP, or Komen Affiliate-funded grants for breast health care services and the percentage of 40- to 64-year-olds with incomes below 250 percent of federal poverty in 2011.

There is limited access to medical facilities that provide care to low-income and uninsured individuals in these communities. Residents in these counties face the additional barrier of transportation due to seasonal closures of mountain passes that are exacerbated by regular closures of Interstate 70, the main highway that both services the region and connects the region with providers in more urban counties in Colorado's Front Range area. Komen Colorado selected residents of Mountain and resort towns as a targeted community because of a number of factors that affect overall breast health outcomes. These factors include: the increasing older female population, the rural and isolated nature of the region, transportation barriers, high costs of living that reduce lower-income residents' disposable income to allocate to breast health crises, large Hispanic/Latina populations, linguistic isolation, residency barriers in some counties, and the overall lack of medical services for low-income and uninsured individuals.

Eagle, Park and Summit Counties currently meet the HP2020 late-stage incidence rate target and are rated as the lowest priority (Table 2.7). Garfield County is likely to miss the HP2020 late-stage incidence rate target and is rated as a medium high priority. The HP2020 late-stage incidence rate target is undetermined for Clear Creek and Pitkin Counties because the data are suppressed due to small numbers of reported data. The HP2020 death rate target is undetermined for all counties except Garfield County because the data are suppressed due to small numbers.

Garfield County has significantly lower screening percentages than the Affiliate service area as a whole with only 45.8 percent of women 40-74 reporting having a mammogram in the last two years (Table 2.8). According to Tables 2.4 and 2.5, this county has a substantially larger population of adults without health insurance and a substantially larger Hispanic/Latina female population than that of the Affiliate service area as a whole. This county has lower WWC screening percentages than the State of Colorado as a whole (Table 2.10). Garfield County's female population between ages 40 and 64 is expected to increase by 21.4 percent between 2010 and 2020 (Table 2.9). Although county-level data about citizenship is limited, anecdotal evidence suggests that uninsured women under 250 percent of FPL aged 40-64 in this county are ineligible for WWC, BCCP or Medicaid because they have been legal permanent residents for less than five years or do not meet other documentation requirements.

Although Eagle, Park and Summit Counties are considered lowest priority based on late-stage incidence rate targets, these counties are included in Komen Colorado's mountain and resort town target community because of the information below.

Eagle County has a lower WWC screening percentage than the State of Colorado (Table 2.10). The female population between the ages of 40 and 64 expected to increase by 30.5 percent for Eagle County between 2010 and 2020 (Table 2.9). According to Tables 2.4 and 2.5, Eagle County has a substantially larger Hispanic/Latina population, substantially larger foreign-born and linguistically isolated populations, and substantially larger percentage of adults without health insurance than the Affiliate service area as a whole. Although only 20 percent of the county is considered rural, there is only one interstate and just two secondary roads in the 1,684 square miles covered by the county and only 31 people per square mile (US Census Bureau). Like Garfield County, anecdotal evidence of past utilization of grant funds awarded by the Komen Aspen Affiliate suggests that uninsured women under 250 percent of FPL aged 40-64 in this county are ineligible for WWC, BCCP or Medicaid because they have been legal permanent residents for less than five years or do not meet other documentation requirements.

Park County is considered 100 percent rural and has a substantially larger female population between the ages of 40 and 65. Only 55.6 percent of women between the ages of 40 and 74 report having a mammogram in the last two years (Table 2.8). Park County has a lower WWC screening percentage than the State of Colorado (Table 2.10), and has no WWC facility in the county. According to the Colorado Rural Health Center, Park County has no hospital, community safety net clinic, or certified rural health clinic within the county boundaries, which requires county residents either to cross county boundaries or mountain passes to access health care services.

Summit County serves as the eastern-most county where screening and limited diagnostic services are available if the pass on Interstate 70 that connects the western side of the state from the Denver-metropolitan region closes. The county's population of women aged 40 to 64 is expected to increase by 20.0 percent between 2010 and 2020 (Table 2.9), predicting an increased demand for providers to deliver breast health care along the entire continuum of care. Summit County has no community safety net clinic or certified rural health clinic (Colorado Rural Health Center). Twenty percent of the county is considered rural (Table 2.5).

Clear Creek has a substantially larger female population between the ages of 40 and 65 compared to the Affiliate as a whole, is considered 100 percent rural and is also classified as 100 percent medically underserved (Tables 2.4 and 2.5). It lacks a hospital, community safety net clinic and/or certified rural health clinic (Colorado Rural Health Center). Breast cancer patients from all mountain and resort towns counties, and residents of Park or Summit Counties seeking diagnostic services in the Denver-metropolitan area, traditionally must travel through Clear Creek along I70 to access care.

Pitkin County has a substantially larger female population between the ages of 40 and 65 than the Affiliate as a whole and 44 percent of the county is considered rural (Tables 2.4 and 2.5). Because of the topography of the region, Pitkin County residents who live in Aspen, Snowmass Village or Basalt primarily receive care in Aspen – including breast health and limited cancer care. The 41-mile distance “down valley” to Glenwood Springs – the next closest municipality that also has a hospital and breast imaging facilities – inhibits Pitkin County residents from seeking primary or preventive care in Glenwood Springs unless medically or financially necessary.

Eagle, Garfield and Pitkin Counties do not have Komen-funded breast cancer treatment programs as the prior Affiliate serving this region did not fund treatment services. Through the qualitative data and health systems analysis sections of this report, the Affiliate will evaluate need for Komen-funded treatment options in the mountain and resort Towns. This may eliminate residents' dependence on I70 being open to access breast cancer treatment in other parts of the Affiliate service area. This specific assessment will supplement overall evaluation of available breast health services in the region, specifically for programs that provide services to uninsured and low-income individuals.

Medically Underserved Communities within Front Range Counties

Based on available data, Komen Colorado's service area is not expected to meet the HP2020 target for female breast cancer late-stage incidence rates of 41.0 cases per 100,000 (Susan G. Komen, 2014, Table 3.2b). Many of the Affiliate's highest-density counties within Colorado's Front Range area are not expected to meet the target rate, disproportionately contributing to the likelihood of the Affiliate service area not meeting that goal. Based on 2010 population estimates from the Colorado Demography Office, six of the seven Front Range counties (Adams, Arapahoe, Broomfield, Denver, Douglas, and Larimer Counties) that are projected to take at least 13 years to achieve the late-stage incidence target (Table 2.7) were home to 60.8 percent of women aged 40-64 who lived within the Affiliate service area (Table 2.9). When adding Weld County's population of women aged 40-64 into the count because that county is projected to take at least 13 years to meet the HP2020 target for female breast cancer deaths (Table 2.7), the seven counties were home to 67.3 percent of women in that age group within the Affiliate's service area. By 2020, those counties are expected to house 70.1 percent of women aged 40-64 within the Affiliate service area.

Because of the large total population within these Front Range counties, Komen Colorado will narrow its focus in these counties to sub-groups with lower incomes who are uninsured or underinsured and who have other demographic factors associated with adverse breast health outcomes. These factors include: living in medically underserved or rural areas within the counties, households with incomes less than 250 percent of the federal poverty level, linguistic isolation, being foreign-born, and lower educational attainment. For this discussion, the Affiliate highlights factors for Front Range counties based on the counties' likelihood of meeting HP2020 targets for the rate of late-stage breast cancer diagnoses and breast cancer death rate.

Although some of the Front Range counties meet the HP2020 target of 41.0 cases per 100,000 for late-stage breast cancer diagnosis, the annual rates are increasing for six of the Affiliate's most populous counties (Table 2.1): Adams (base rate of 41.3 per 100,000, increasing at 10.4 percent annually), Arapahoe (base rate of 43.2, increasing at 2.6 percent annually), Broomfield (base rate of 42.4, increasing at 4.8 percent annually), Denver (base rate of 46.6, increasing at 5.2 percent), Douglas (base rate of 42.7, increasing at 6.9 percent) and Larimer (base rate of 42.3, increasing at 2.6 percent annually). Assuming late-stage diagnoses follow these annual trends, these counties are unlikely to meet the HP2020 target. Moreover, Blacks/African-Americans (base rate of 57.2, increasing at 8.9 percent annually) and Asian/Pacific Islanders (API) (base rate of 22.8, increasing at 27.6 percent annually) within the Affiliate's service area are experiencing increasing rates for late-stage diagnosis, raising questions about health inequities faced by these populations that the Affiliate may investigate further in its qualitative analysis. This is particularly true for Arapahoe, Broomfield and Denver Counties, which have

substantially higher proportions of Black/African-American or API populations than the Affiliate service area as a whole (Table 2.4).

Social determinants of health affecting certain sub-populations within the counties with increasing rates of late-stage diagnosis include lower educational attainment (Adams and Denver Counties), household income below 250 percent federal poverty level (Adams and Denver), being foreign born (Adams, Arapahoe and Denver), linguistic isolation (Adams and Denver), living in rural (Douglas and Larimer) or medically underserved areas (Denver), and being uninsured (Adams and Denver). In addition, because late-stage incidence trends reflect both the overall breast cancer incidence rate in the population and the mammography screening coverage, Komen Colorado notes that Adams County lags the Affiliate service area in number of women 50-74 who had a mammogram in the last two years (Table 2.3). Each of these factors will be examined in the qualitative section of this report.

Weld is the only Front Range County that risks not meeting the HP2020 target for female breast cancer deaths because of its rising annual trend rate of 11.0 percent (Table 2.1). The breast cancer death rate reflects access to care and the quality of care in the health care delivery area as well as stage of cancer at diagnosis. While Weld County's late-stage diagnosis rate currently meets the HP2020 target and is trending downward, the county has sub-populations characterized by social determinants of health that adversely affect breast health. These factors include: lower educational attainment (14.8 percent), household income below 250 percent federal poverty level (31.1 percent), being uninsured (17.3 percent), and living in rural (20.5 percent) or medically underserved (23.3 percent) areas. Each of these factors will be examined as barriers to regular screening mammograms and adherence to prescribed treatment if diagnosed with breast cancer in the qualitative section of this report.

In its qualitative and health systems analyses, the Affiliate will examine barriers to breast health care services among uninsured or underinsured women with household incomes below 250 percent of the federal poverty level who also live in medically underserved areas or rural parts of the counties; who are linguistically isolated and/or foreign-born; or who have attained less than a high school education. The Affiliate anticipates analyzing data from BRFSS to identify common socioeconomic, health status, or other factors among women aged 40-74 who reported they had not received a mammogram in the last two years to further refine the Affiliate's focus in Front Range counties.

Within all Front Range counties, Komen Colorado also is sensitive to demographic forecasts for the number of women aged 40-64 expected to live within the Affiliate service area. Komen Colorado uses these forecasts to project whether need for breast health care services will increase, decrease, or stay consistent compared to current levels. Looking forward through 2020, the Front Range counties are expected to experience substantial increases in their populations of women aged 40-64, which the Affiliate expects will drive demand for breast health care providers and funding to pay for breast health care services. On a per-county basis between 2010 to 2020, the populations of women aged 40-64 in the counties discussed above are projected to increase by 21.6 percent in Weld County, 22.5 percent in Adams County, 17.8 percent in Denver County, 23.7 percent in Broomfield County, 22.9 percent in Douglas County, 11.0 percent in Arapahoe County, and 8.0 percent in Larimer County (Table 2.9).

While the above counties will be targeted for deeper analysis through qualitative assessments, the Affiliate recognizes that location of residence does not correspond to location(s) where women receive breast health care services. As such, the Affiliate expects providers located in Boulder and Jefferson Counties – both currently ranked as “medium-low” and “low” priorities for Komen Colorado interventions (Table 2.7) – to be identified as critical resources for medically underserved communities to access service along the breast health continuum of care. The Affiliate also anticipates qualitative analyses for the Hispanic/Latina target community discussed above will reveal population-specific barriers within that community that are present within all Front Range counties, including Boulder and Jefferson.

Health Systems and Public Policy Analysis

Health Systems Analysis Data Sources

Komen Colorado retained an intern to conduct an inventory of breast health services provided among health care providers within the Affiliate's service area (see Appendix B: Inventory Tool for Continuum of Care Providers). The resulting database includes nonprofit and for-profit health care facilities of various types, including:

- Cancer centers
- City or county health departments
- Community health centers
- Federally Qualified Health Centers (FQHCs)
- FQHC look-alikes (meet FQHC standards but do not receive federal FQHC grant funding)
- Free clinics
- Hospices
- Hospitals
- Imaging centers
- Rural health centers
- Surgical outpatient facilities
- Women's health clinics
- Other types of providers or organizations

The list of providers was built from:

- current and past organizations that had received grants from the Denver-metropolitan and Aspen Affiliates of Susan G. Komen
- the names of surgery, oncology, radiology, and other specialty-care providers that grant recipients partner with to coordinate breast cancer patients' care
- a list of health care providers, key informants, and community stakeholders that were interviewed by the Denver-metropolitan Affiliate during the production of its 2011 Community Profile (updated to reflect changes in personnel)
- a list of the Women's Wellness Connection (WWC) providers provided by the Colorado Department of Public Health and Environment;
- a list of women's health clinics provided by the Colorado Ovarian Cancer Alliance; and
- a Colorado health system analysis developed by Susan G. Komen (2014) indicating whether the provider offered screening, diagnostic, treatment, or patient support services.

The intern identified 531 facilities that provided some type of breast health services. Due to resource constraints, the Affiliate narrowed its inventory of providers to 358 facilities that were known to prioritize provision of services on the breast health continuum of care. Examples of inventoried providers include cancer treatment centers, Women's Wellness Connection sites, health care systems that currently or previously received grant funding from the Affiliate, and safety net or community health centers more likely to be used as medical care homes by medically underserved populations within the Affiliate's target communities.

The 173 facilities that were excluded from aggressive data collection were largely private ob/gyn providers whose primary scope of health care is obstetrical and gynecological services. Although these providers may include clinical breast exams during patient visits, these providers are expected to refer patients to another location for mammography, diagnostics, or other breast health specialty care. The Affiliate prioritized the inventory of locations where patients/clients were referred.

The intern developed an inventory instrument to capture information about the following:

- the provider's organization name, contact information and type of facility;
- whether the organization had a separate foundation to raise money to support the organization's health care service provision, and if so, development staff contact information;
- contact information for breast health navigators or practice managers;
- which scope of services along the breast health continuum of care were provided by each organization or where patients/clients were referred for care;
- accreditation(s);
- types of payment accepted for patient/client care, such as Medicaid, Medicare, the Colorado Indigent Care Program (CICP), self-pay, veteran's administration/Tri-Care, private insurance, or Women's Wellness Connection (WWC);
- whether the organization participates in any of the regional coordinated care organizations (RCCO) or payment reform models being piloted in Colorado under the Affordable Care Act;
- the federal poverty level used by the organization to determine patient/client eligibility for charity care;
- estimates of the percentage of client/patient population characterized as belonging to the Affiliate's target communities of rural northeast Colorado, mountain and resort towns, medically underserved populations in Front Range counties, or Hispanic/Latina women;
- estimates of non-citizens served; and
- languages other than English used with patients/clients.

The inventory instruments were distributed via email to project directors of organizations that were awarded grants from the Affiliate during the 2013-14 and 2014-15 grant cycles to complete and return by fax. For all other provider types, the intern called organizations directly to collect data verbally, as well as sent the survey via email and fax with a request to return by fax.

Among the 358 facilities, 264 responded, yielding a 73.7 percent response rate. For the 94 non-respondents, the intern used the following online resources to gather information about accreditation, quality of care indicators, Medicare/Medicaid acceptance, CoC services offered, and facility type:

- Colorado Consumer Health Initiative's *The Blue Guide: Connecting Care and Health in Colorado – A Guide to Services for the Uninsured* (4th Edition)
- American College of Surgeons Commission on Cancer
- American College of Radiology Centers of Excellence
- American College of Surgeons National Accreditation Program for Breast Centers (NAPBC)
- National Cancer Institute Designated Cancer Centers
- FDA-approved Mammography Centers

- US Centers for Medicare and Medicaid Services (CMS) registry of hospitals registered with Medicare
- Health Resources and Services Administration's Community Health Center Directory
- National Association of Free and Charitable Clinics
- National Association of County and City Health Officials directory of local health departments

The Community Profile intern used mapline.com to map out respondents' answers about which services along the CoC are provided throughout the Affiliate's service area. Four maps were created - one each for screening, diagnostic, treatment, and support services - to depict locations of providers. The Affiliate used these maps to assess number of providers and gaps in the CoC in each of the geographically selected target communities (i.e., mountain and resort region, rural northeast region, and Front Range region). The intern also created a map of all CoC providers that indicated they serve Hispanic/Latina patients.

Health Systems Overview

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

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

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

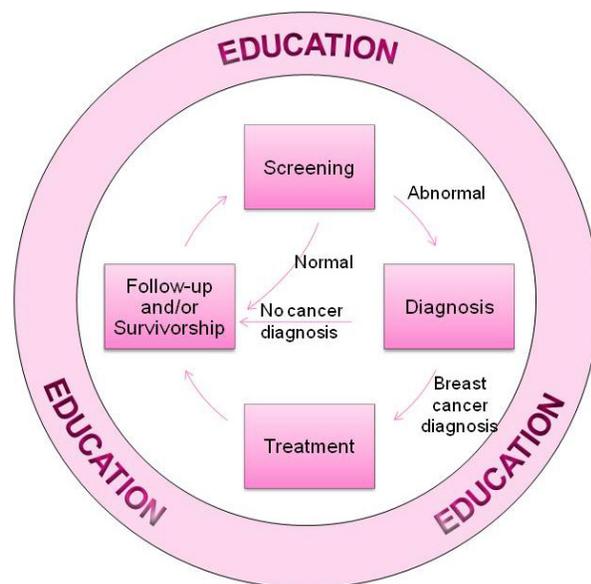


Figure 3.1. Breast Cancer Continuum of Care (CoC)

If a woman is diagnosed with breast cancer, 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 woman may have for her providers.

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

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

Summary of Findings – Health Systems Inventory

Key findings of the inventory are detailed below by stage of the continuum of care. Of note, the Affiliate sought information about the type of payment method accepted by providers along the CoC. This is because the Affiliate seeks to understand potential gaps in access to breast care attributable to insufficient numbers of providers that accept the patient's source of payment. With Colorado's decision to expand Medicaid, there is an increased need for providers – primary care as well as breast cancer specialists – to accept new Medicaid patients. This will be discussed in more detail in the section below that examines the effects of the Affordable Care Act on the Affiliate. This summary of key findings below also indicates the number of providers identified by the Affiliate that accept Medicaid for each component of the CoC. However, information about providers' acceptance of Medicaid could be underreported due to inclusion of facilities that do not charge for services, respondents that did not indicate whether their facility accepts Medicaid, or lack of verifiable information about Medicaid/Medicare acceptance through online resources.

Screening Providers: 254 respondents indicated they provide some form of screening services. By removing providers that only indicated provision of patient navigation for screening, 237 providers within the Affiliate service area offer breast-screening services (i.e., clinical breast exam, mobile mammography screening with digital screening, mobile mammography screening with tomosynthesis, in-clinic screening mammography, or screening mammography with tomosynthesis). Of the screening providers, 117 (49.4 percent) indicated they accept Medicaid.

Diagnostic Providers: 161 respondents indicated they provide some form of diagnostic services. When removing providers that only indicated provision of patient navigation for diagnostics, 90 providers within the Affiliate service area offer breast diagnostic services (i.e., diagnostic mammography, ultrasound, biopsy, MRI, or surgical consult). Of the respondents that indicated they provide diagnostic services, 52 (57.8 percent) indicated they accept Medicaid.

Treatment Providers: 133 respondents indicated they provide treatment services. When removing providers that only indicated provision of patient navigation for treatment, 54 providers within the Affiliate service area offer breast treatment services (i.e., radiation, chemotherapy, surgical consult, surgery, or reconstruction). Of the respondents that indicated they provide treatment services, 32 (59.3 percent) indicated they accept Medicaid.

Support Providers: 103 respondents within the Affiliate service area indicated they provide support services (i.e., support groups, side effect management, individual counseling/psychotherapy, exercise/nutrition programs, complementary therapies, financial assistance, legal services, or end-of-life care). Of the respondents that indicated they provide support services, 83 (80.6 percent) indicated they accept Medicaid for services covered by insurance.

For providers that indicated they referred patients to other facilities to receive services on the CoC, the following were listed most frequently as the places to which patients were referred:

- Women's Wellness Connection provider
- Sisters of Charity of Leavenworth (SCL)'s Saint Joseph Hospital Breast Cancer Center and mobile mammography unit
- Centura's St. Anthony Hospital and Summit Medical Center
- Women's Imaging Center
- Invision Sally Jobe, and
- University of Colorado Health.

Referrals also depended on patients' geographic location, form of insurance and proximity to nearby facilities. Understanding common locations for referrals will enable the Affiliate to ensure it cultivates strong relationships with those providers to promote access to care for the Affiliate's target communities.

Within all target communities, potential new partnerships include for-profit imaging centers and surgical centers that partner with Komen grant recipients for screening, diagnostics and breast surgery. Federally qualified health centers, free clinics and nonprofit clinics that serve as medical homes and entry points for breast cancer education and screening are potential mission partnerships. Community-based organizations, such as literacy programs, senior centers, and immigrant services programs, are potential partners to provide breast health education.

Some respondents indicated they provided breast health services to patients who live outside of the Affiliate service area, including patients from Grand, Kit Carson and Routt Counties. Responses from those providers are not included in the analyses below unless the providers also serve patients in the Affiliate's target communities.

Implications for Target Communities

Hispanic/Latina Population

Among all providers, 140 indicated their patient population included Hispanic/Latina women (Figure 3.2). All six of the counties shown in Table 2.4 of the Quantitative Data Section that have higher percentages of Hispanic/Latina women than the Affiliate service area as a whole (Adams, Denver, Eagle, Garfield, Morgan, and Weld Counties) had respondents providing services along the full CoC. In fact, Broomfield and Clear Creek were the only counties in the Affiliate service area that did not have providers that indicated they served Hispanic/Latina patients.

Among the 140 respondents that indicated they served Hispanic/Latina patients/clients, 107 provide screening services, 53 provide diagnostic services, 49 provide treatment services, and 90 provide support services (again, excluding respondents that indicated only patient navigation). Given respondents' indication that Hispanic/Latina women are among their patient/client populations, the Affiliate will explore other factors beyond existence of providers that may contribute to adverse breast health outcomes among Hispanic/Latina women within the Affiliate service area. In addition, Table 3.1 provides a summary of the accredited facilities available for Hispanic/Latina women.

Table 3.1. Accreditation of facilities for Hispanic/Latina women

Accreditation Source	Number of Facilities
American College of Surgeons Commission on Cancer	22
American College of Radiology Breast Imaging Center of Excellence	23
American College of Surgeons National Accreditation Program for Breast Centers	12
NCI Designated Cancer Center	1

Denver, Morgan, Adams, Garfield and Eagle Counties have the highest percentages of Hispanic/Latina populations. Despite having providers that indicated they provide breast health services to Hispanic/Latina women, residents in Morgan County may have more barriers in access to breast health services than those in Denver County. In Morgan County there are four facilities that provide screening (two indicated they serve the Hispanic/Latina population), two facilities that provide diagnostics, zero facilities that provide treatment, and one facility that provides support. As a result, Hispanic/Latina women in Morgan County may have to travel to Denver, Weld, Logan, or Washington Counties to get treatment for breast cancer. Residents who live in central and eastern parts of Adams County may also face the same barriers to access as Morgan County, as most services are located toward the western part of the county.

Out of 358 providers across the 22 county service region, 141 organizations indicated that a portion of their patients speak Spanish with translation services available. While Hispanic/Latina identification is not synonymous with Spanish as primary language spoken, the Affiliate does recognize lack of medical information in the patient's native language could act as a barrier to care. Among the 108 providers that indicated they provided screening services to the Hispanic/Latina population, 93 providers indicated that these facilities had translation services. Among the 32 providers that indicated they provided diagnostic services to the Hispanic/Latina population, 27 providers indicated that these facilities had translation services. Among the 23 providers that indicated they provided treatment services to the Hispanic/Latina population, 20

providers indicated that these facilities had translation services. Among the 92 providers that indicated they provided support services to the Hispanic/Latina population, 85 providers indicated that these facilities had translation services. Although these facilities are serving the Hispanic/Latina population, language may act as a barrier that prevents patients from receiving the best care possible, which includes fully understanding the services they receive. Recognizing the Hispanic/Latina population is not homogenous, the Affiliate will use qualitative assessments to explore how immigration status, cultural issues, myths about breast/women's/general health care, disparities in insurance coverage, and income may act as barriers to care for this population.

Among providers who have translation services for the Hispanic/Latina population in Adams County, nine facilities provide screening, three provide diagnostic services, zero provide treatment, and three provide support. Spanish-speaking residents may have to travel to facilities in Denver or Washington Counties to seek treatment with translation services, requiring patients to secure time off from work, transportation, lodging if recovery from treatment prevents returning home the day of treatment, and in some cases, child care.

Residents living in the western part of Garfield County may face barriers in access to care. Among providers who have translation services for the Hispanic/Latina population in Garfield County, four indicate they provide screening, two indicate they provide diagnostics, two provide treatment, and four provide support services. Although all types of services are located in the county, the county covers nearly 3,000 square miles but cancer care facilities are provided only along the main highway that bisects the county. This requires people who live in more rural regions to travel a long distance to seek care with translation services; for those who live along the main highway, distances could be 90 miles round-trip. For those who live off the highway, the time and distance would be longer because of the need to use single-lane, or in some cases, unpaved roads to get to the main highway before navigating to cancer care facilities. This may not be feasible in winter months when smaller roads are not maintained, or for those without their own vehicle who rely on public transportation or others for their travel needs.

Among providers who have translation services for the Hispanic/Latina population in Eagle County, two facilities provide screening, one facility provides diagnostics, one facility provides treatment, and two provide support. Services in Eagle County are centrally located off the main highway that bisects the county, but residents living closer to the borders of Eagle County may travel to Garfield or Summit Counties to receive care. They would face the same barriers identified for Garfield County residents in terms of transportation, distance, and potential closures on the highway's high-elevation mountain passes during winter months.

Among providers that have translation services in the rural northeast region, 11 providers provide screening services throughout all six counties; three providers in Logan, Washington and Yuma Counties provide diagnostic services; three providers in Logan, Washington, and Yuma Counties provide treatment; and three providers in Logan, Washington, and Yuma Counties provide support services. Spanish-speaking Hispanic/Latina women living in the rural northeast counties of Sedgwick and Morgan Counties may be disproportionately affected due to lack of services available with translation. All counties are extremely rural, raising the same requirement of patients to secure time off from work, transportation, lodging if recovery from treatment prevents returning home the day of treatment, and in some cases, child care.

The Affiliate sought supplementary data from the Colorado Cancer Registry to identify disparities in breast cancer indicators between Hispanic/Latina and non-Hispanic/Latina populations in the counties served by the organization. These data showed Hispanic/Latina women in Weld County had an age-adjusted breast cancer death rate of 27.5 per 100,000 individuals for 2007-2011, substantially higher than the rate of 19.5 for the Affiliate as a whole and the rate of 24.2 for non-Hispanic/Latina populations in the county. Through its qualitative assessment, the Affiliate will explore additional factors that could drive this disparity in Weld County as a result of the limited number of breast health providers, including language and cultural barriers, travel expenses, daycare expenses, and lost wages when taking time off from work.

The Affiliate will continue to maintain strong relationships with current and former grant recipients that serve Hispanic/Latina women to ensure medically underserved women and men have access to low-cost or free breast health and breast cancer care.

Salud Family Health Centers, Clinica Family Health Services, Metro Community Provider Network (MCPN), Denver Health, SCL St. Joseph's Breast Cancer Center and mobile mammography unit, University of Colorado Health, Mountain Family Health Centers (MFHC) and Planned Parenthood of the Rocky Mountains (PPRM) are key providers to screen and navigate Hispanic/Latina women in the five counties that have higher percentages of Hispanic/Latina women than the Affiliate service area as a whole. In addition, community-based organizations like Community Research Education Awareness (CREA Results) in Denver act as a vital gateway to providing breast self-awareness education to Spanish-speaking populations throughout the Front Range communities. Of note, several providers across the CoC that serve Hispanic/Latina patients from Broomfield (a county with no Hispanic/Latina-serving providers), southwestern Weld County, southern Larimer County, and northwestern Jefferson County are located in Boulder and Jefferson Counties – two counties not identified in the Affiliate's selection of target communities. Maintaining relationships with those providers, including Boulder Community Hospital, Boulder Valley Women's Health, and Longmont United Hospital, will be important to maintain continuity of access for Hispanic/Latina women in that region.

Hispanic/Latina women benefit from collaboration fostered in all Komen regional coalitions where Affiliate grant recipients, Women's Wellness Connection, American Cancer Society, and other community providers attend. Potential new partnerships include those identified for the geographically oriented target communities as well as community-based organizations aimed at increasing health insurance enrollment among Colorado Hispanic/Latina populations and immigrant services programs to provide breast health education and referral to resources.

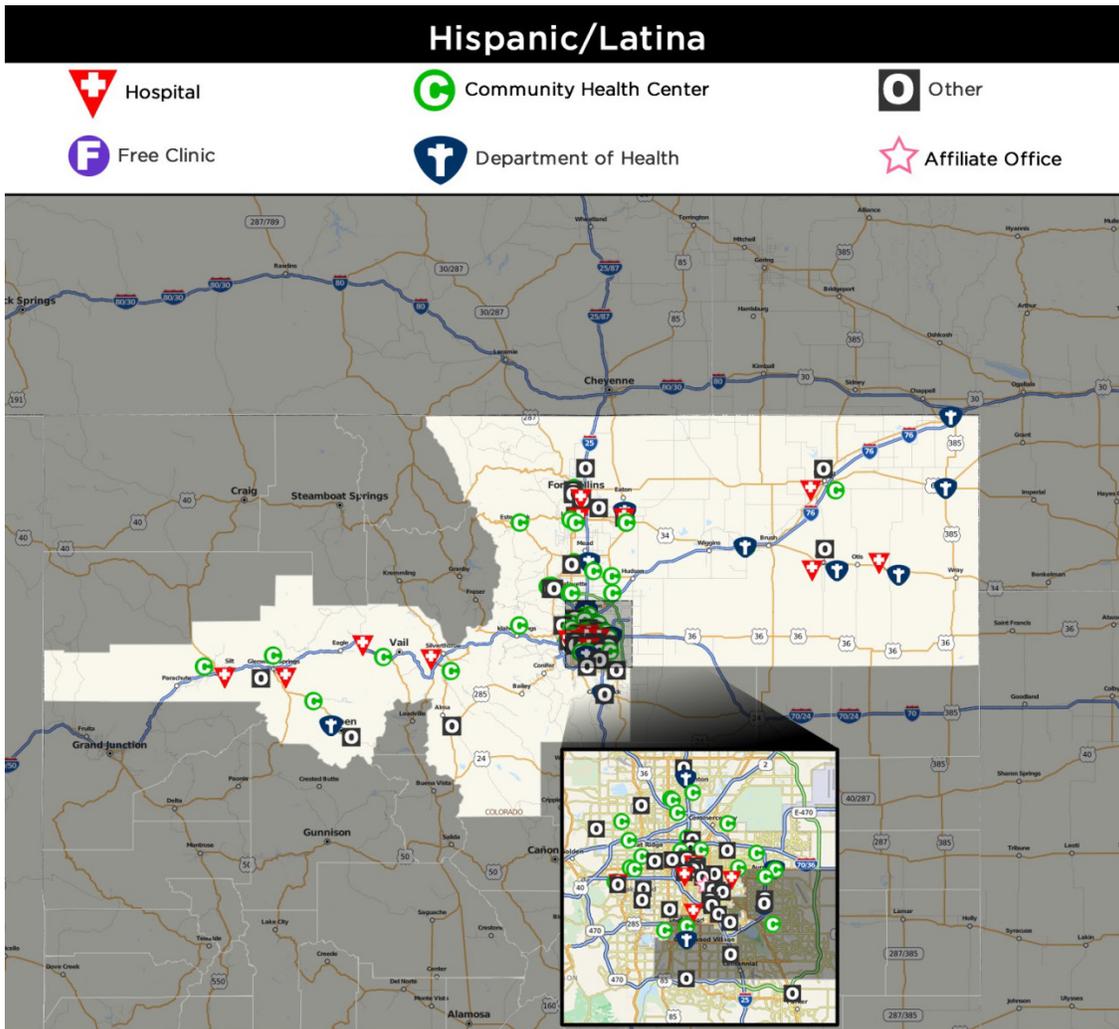


Figure 3.2. Breast cancer services available for Hispanic/Latina women

Rural Northeast Colorado

Within rural northeast Colorado overall, 124 respondents indicated their patient population included residents from rural northeast Colorado residents (Figure 3.3). However, not all 124 respondents are located within the six counties, suggesting residents from this region travel to access breast health care services. For example, a mobile mammography unit operated by Denver-based SCL Saint Joseph has provided mammography screening in this region upon request. Within this region, 10 respondents provide screening services, five provide diagnostic and treatment services, and four provide support services, removing providers that indicated only patient navigation.

Throughout this region, breast health screening services in each county are located along major transit routes; diagnostic services are available in each county; treatment services are located in each county except for Morgan and Phillips Counties; and support services are located in each county except for Sedgwick and Phillips Counties. Based on the data gathered for the rural northeast region, accessing treatment may be the biggest barrier for those who live in the rural northeast region. Those who live in Phillips County may be disproportionately affected because Komen Colorado was unable to identify any treatment or support services within the county. Breast cancer patients in Sedgwick and Phillips Counties are likely to face barriers accessing

support services. In each county without a provider, residents likely need extra time to access care compared to their counterparts in other locations where services are available locally. The Affiliate should explore related burdens when accessing care in this region, such as not being able to take time off of work or lost wages if they do take time off for diagnostic or treatment care; and additional expenses associated with traveling to access care, such as daycare, lodging and gas expenses.

Table 3.2 provides a summary of the accredited facilities within rural northeast Colorado.

Table 3.2. Accreditation of facilities for rural northeast Colorado

Accreditation Source	Number of Facilities
American College of Surgeons Commission on Cancer	0
American College of Radiology Breast Imaging Center of Excellence	0
American College of Surgeons National Accreditation Program for Breast Centers	0
NCI Designated Cancer Center	0

The Affiliate will continue to maintain strong relationships with Komen current and former grant recipients within the rural northeast Colorado target community to ensure medically underserved women and men have access to low-cost or free breast health and breast cancer care. The Affiliate has served these counties since 2010 with expansion of the Affiliate service area. For example, the Affiliate awarded a grant to provide financial assistance for breast cancer patients who must travel at least 60 miles to access care to offset transportation and lodging expenses that were identified as barriers to patients’ adherence to their treatment plans.

Due to the rural nature of these counties, community health clinics, such as Salud Family Health Centers and Plains Medical Center, and community-based organizations such as Rural Solutions, are key partners with Komen to educate and screen women. Due to limited imaging centers within rural northeast Colorado, the SCL St. Joseph mobile mammography van has been an important partner. There are limited medical facilities within these six counties. Yuma County Hospital and the David Walsh Cancer Center at Sterling Regional Medical Center provide some aspects of breast cancer treatment. Many individuals travel to Front Range medical facilities for cancer treatment.

The Komen Northeastern Colorado Coalition meets quarterly with the purpose of: increasing collaboration among grant recipients and other organizations providing breast health services; reducing duplication of services; and making the continuum of care a more seamless system for rural northeast Colorado. Komen grant recipients, Rural Solutions, Women’s Wellness Connection, American Cancer Society, and community providers are attending the coalition meetings. This coalition is a vehicle to engage potential partners in Komen’s work.

Potential new partnerships include chamber of commerce programs, women’s groups, and large employers such as JBS Swift and large-scale farm operations. Community-based organizations such as resource centers, senior centers, and immigrant rights programs also may be potential partners to provide breast health education and referral to resources.

Rural Northeast Colorado

 Hospital
 Community Health Center
 Other
 Free Clinic
 Department of Health
 Affiliate Office

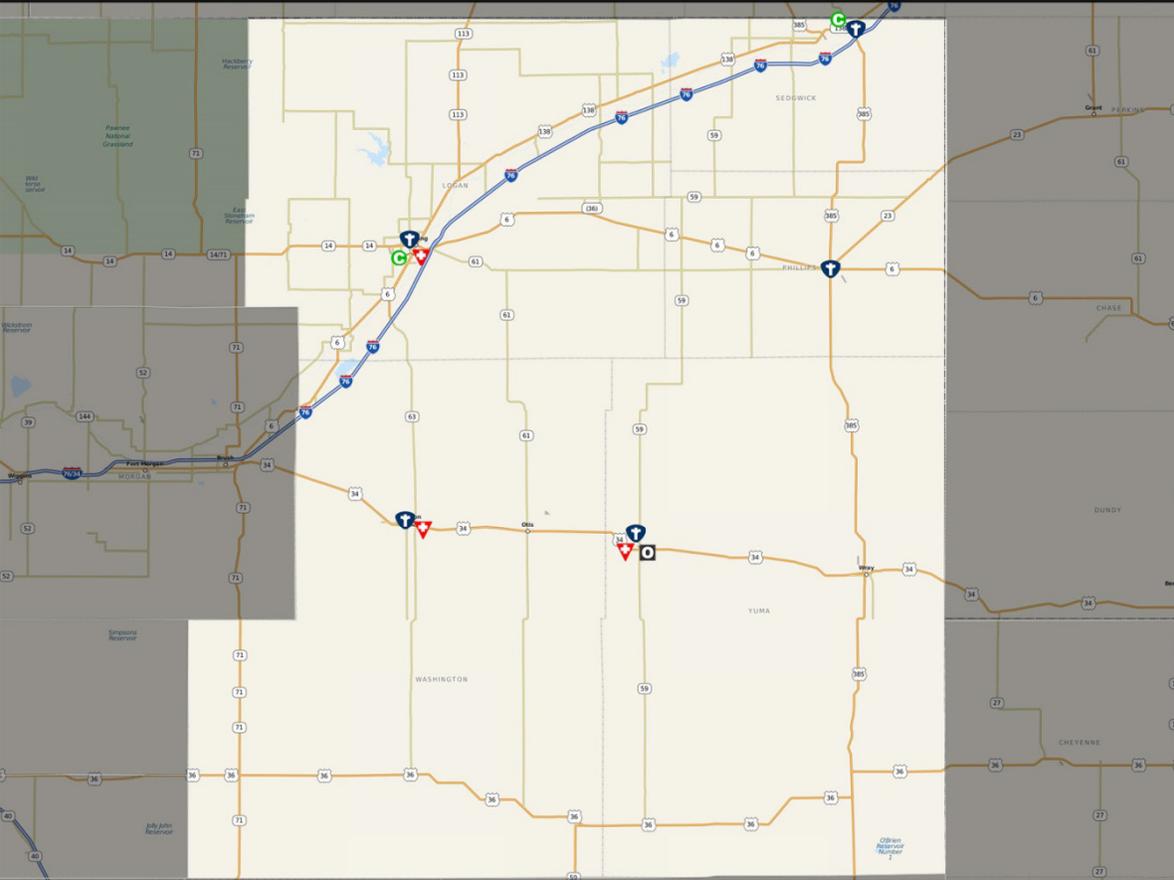


Figure 3.3. Breast cancer services available in rural northeast Colorado

Mountain and Resort Towns

Within the six counties that comprise the mountain and resort target community, the Affiliate identified 15 respondents that provide screening services, 10 that provide diagnostic and treatment services, and 18 that provide support services, excluding providers that indicated only patient navigation (Figure 3.4). In addition, Table 3.3 provides a summary of the accredited facilities within the mountain and resort towns.

Table 3.3. Accreditation of facilities for mountain and resort towns

Accreditation Source	Number of Facilities
American College of Surgeons Commission on Cancer	2
American College of Radiology Breast Imaging Center of Excellence	1
American College of Surgeons National Accreditation Program for Breast Centers	0
NCI Designated Cancer Center	0

Like the rural northeast region, there were more respondents (115) that indicated their patient population included individuals from mountain and resort communities than the number of providers located in the region. Again, this indicates residents from mountain and resort communities travel outside of their local community to access breast health care. Also like the rural northeast region, the SCL Saint Joseph Hospital mobile mammography unit has provided mammography screening to residents in Park County previously but future capacity to continue providing services is unknown.

In the mountain resort region, there are breast health screening providers in each county; diagnostic and treatment services are available in each county except for Park and Clear Creek Counties; and support services are available in each county. Although screening and support services exist in all mountain and resort counties, people who live in the western part of Garfield County and southern part of Park County may have to travel a long way to reach these services, as they are not centrally located and live in a more rural region. Residents in Park and Clear Creek counties may be affected disproportionately because getting diagnostic and treatment services would mean traveling cross-county to access care. As with women in rural northeast Colorado, residents in those counties may have to use extra time and incur additional expenses when accessing care. The Affiliate should explore related burdens for patients who access care in this region, such as not being able to take time off of work or lost wages if they do take time off for care; and additional expenses associated with traveling to access care, such as daycare, lodging and gas expenses.

Some providers located in the northeast region of Colorado indicated they serve mountain and resort residents, despite the distance between the two geographic regions. One explanation for this anomaly is respondents may have interpreted the question asking about patient populations served to mean whether there are restrictions on who can receive care. While residents of mountain and resort communities may not travel that far to receive care in rural northeast Colorado, if they needed services, they would not be turned down.

The Affiliate will continue to maintain strong relationships with Komen current and former grant recipients within the mountain and resort towns target community to ensure medically underserved women and men have access to low-cost or free breast health and breast cancer care. The Affiliate has had a presence in Clear Creek, Park and Summit for many years, and the relationships with grant recipients are strong. Eagle, Garfield and Pitkin Counties became part of the Affiliate service area as of December 31, 2013, with the merger of Aspen and Denver Affiliates. The relationships with grant recipients within these counties are not as established; therefore, a focus of the Affiliate will be to continue to strengthen these partnerships.

Breast cancer treatment funds have not historically been available in Eagle, Garfield or Pitkin Counties. With the merger, Komen treatment funds became available beginning in 2015. The Sonnenalp Breast Center at Shaw Regional Cancer Center and Calaway Young Cancer Center at Valley View Hospital are two potential key partnerships for the Affiliate to increase access to breast cancer treatment. Additionally, two current grant recipients, Aspen Valley Hospital and Grand River Hospital provide some aspects of treatment.

Park and Clear Creek Counties do not have a hospital, community safety net clinic or certified rural health clinic within the county boundaries. SCL Saint Joseph's mobile mammography unit has been an important partner within these counties providing screening mammograms, and

Saint Joseph Hospital and other Komen treatment grant recipients have provided follow-up diagnostics and care as needed. Invision Sally Jobe Breast Imaging Center in the greater Denver area partners with Aspen Valley Hospital by sending physicians to Aspen on a regular basis.

The Affiliate recently launched the Komen Roaring Fork/I70 Corridor Coalition with the purpose of: increasing collaboration among grant recipients and other organizations providing breast health services; reducing duplication of services; and making the continuum of care a more seamless system for mountain and resort towns. Komen grant recipients, Women’s Wellness Connection, American Cancer Society, and community providers are attending the coalition meetings. This coalition is a vehicle to engage potential partners in Komen’s work.

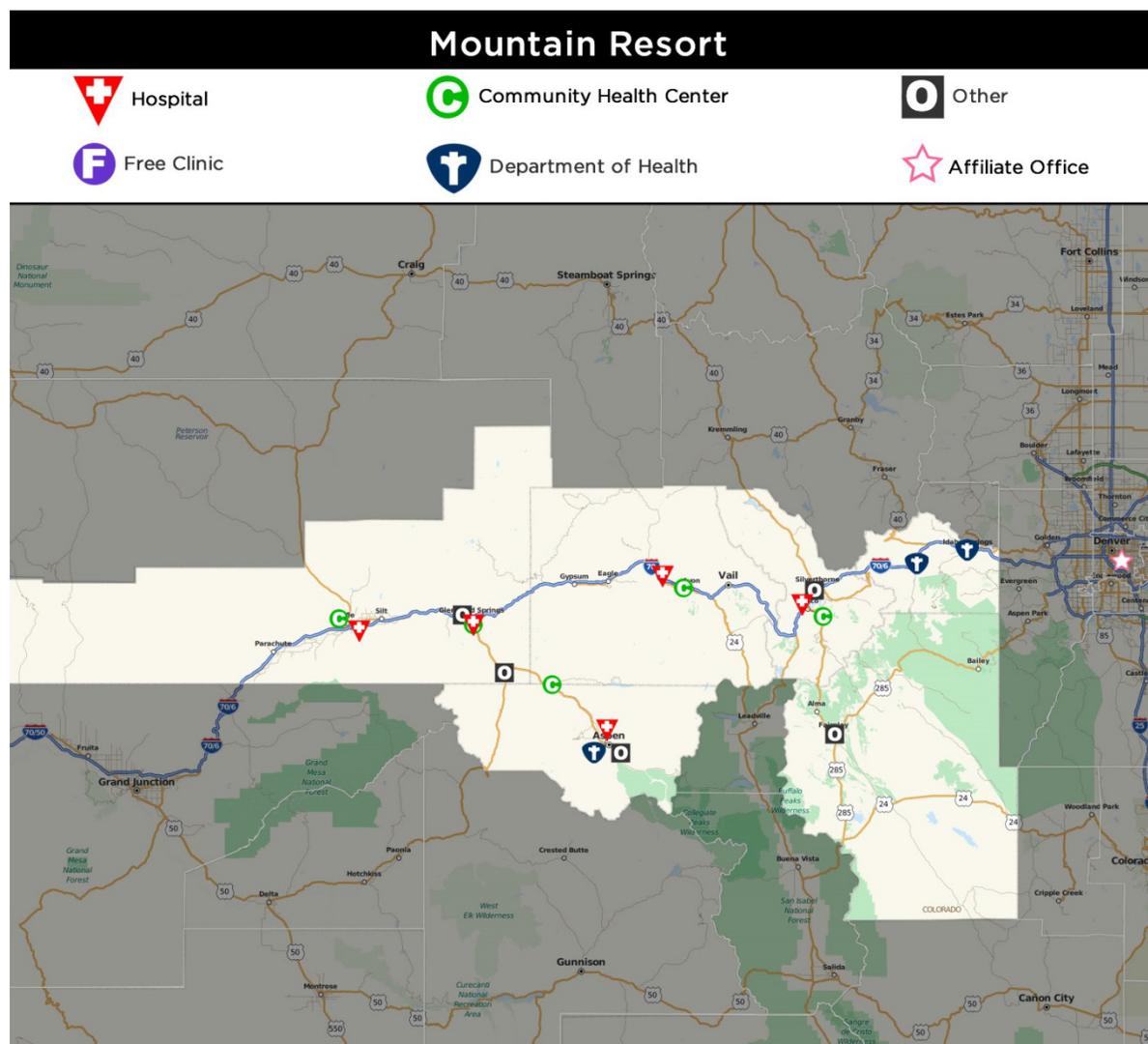


Figure 3.4. Breast cancer services available in mountain and resort counties

Medically Underserved Communities within Front Range Counties

A summary of services provided within Front Range counties with medically underserved communities that have been identified as a target community of the Affiliate’s is listed by county below (Figure 3.5).

- Adams County: The Affiliate identified eight screening providers, and two providers of diagnostic, treatment, and support services, excluding providers that indicated only patient navigation.
- Arapahoe County: The Affiliate identified 25 screening providers, 17 diagnostic providers, five treatment providers, and 14 locations that provide support services, excluding providers that indicated only patient navigation. One health system, University of Colorado Health, offers mammography via a mobile unit to patients with insurance. The Affiliate was unable to determine whether this mobile unit has increased screening capacity regionally by providing screenings at locations outside of Denver County.
- Broomfield County: The Affiliate identified two screening providers and zero providers of other services along the breast cancer continuum of care.
- Denver County: The Affiliate identified 50 screening providers, 17 diagnostic providers, seven treatment providers, and 31 locations that provide support services, excluding providers that indicated only patient navigation. Among the screening providers are two health systems (SCL Saint Joseph, Denver Health) that offer screening mammograms through a mobile unit. While the SCL Saint Joseph unit has provided access in other regions of the Affiliate service area (as well as the other Front Range counties within this target community), the Denver Health unit is limited to serving uninsured clients/patients from the City and County of Denver – which does not increase overall screening capacity in other counties.
- Douglas County: The Affiliate identified 10 screening providers, six diagnostic providers, two treatment providers, and four locations that provide support services, excluding providers that indicated only patient navigation.
- Larimer County: The Affiliate identified 20 screening providers, eight diagnostic providers, six locations that provide treatment services, and 12 locations that provide support services, excluding providers that indicated only patient navigation.
- Weld County: The Affiliate identified 17 screening providers, six diagnostic providers, two treatment providers, and 14 locations that provide support services, excluding providers that indicated only patient navigation.

Table 3.4 provides a summary of the accredited facilities within the Front Range counties.

Table 3.4. Accreditation of facilities for medically underserved women within Front Range counties

Accreditation Source	Number of Facilities
American College of Surgeons Commission on Cancer	20
American College of Radiology Breast Imaging Center of Excellence	22
American College of Surgeons National Accreditation Program for Breast Centers	12
NCI Designated Cancer Center	1

Based on the data shown on the map, residents living in the rural areas of northwestern Larimer County, eastern Adams and Arapahoe Counties, southern Douglas County, and northeastern Weld County may have the same barriers in accessing breast health services as those in rural northeast Colorado and mountain and resort towns. Most services are located near the cities in these counties, which may leave those living on the outer part of the county with distance-related barriers to care. This is consistent with the county descriptions in the Quantitative Data Section Table 2.5 indicating substantial percentages of the counties' populations live in rural and/or medically underserved areas. The Affiliate should explore burdens related to having to travel to access care in counties, such as not being able to take time off of work or lost wages if they do take time off for diagnostic or treatment care; and additional expenses associated with traveling to access care, such as daycare, lodging and gas expenses.

As with other target communities, the Affiliate will maintain strong relationships with current and former grant recipients that serve medically underserved women and men in Front Range counties to ensure continuous access to low-cost or free breast health and breast cancer care.

Because of overlap in providers that serve Hispanic/Latina populations, the Affiliate considers the same providers and community-based organizations critical to ensuring care in Front Range counties. In addition, Tri-County Health Department provides services to lower-income women and men in Adams, Arapahoe, and Douglas Counties who may not be able to access breast care elsewhere. Also like with the Hispanic/Latina target community, several providers across the CoC that serve medically underserved communities from Front Range counties are located in Boulder and Jefferson Counties. Maintaining relationships with those providers will be important to maintain continuity of access for medically underserved women and men in those counties.

Medically underserved women and men in Front Range counties also benefit from collaboration fostered in the Denver-metropolitan, Larimer County Women's Health, Weld County and Boulder/Broomfield Komen regional coalitions. As with other regional coalitions, Affiliate grant recipients, Women's Wellness Connection, American Cancer Society, and other community providers participate in these coalitions to increase collaboration, facilitate referral of breast cancer patients in need of access to resources, and increase public awareness of breast cancer risk. Potential new partnerships include those already identified for the Hispanic/Latina populations as well as community-based organizations like AARP and Seniors Resource Center and major employers of medically underserved populations in each of the counties.

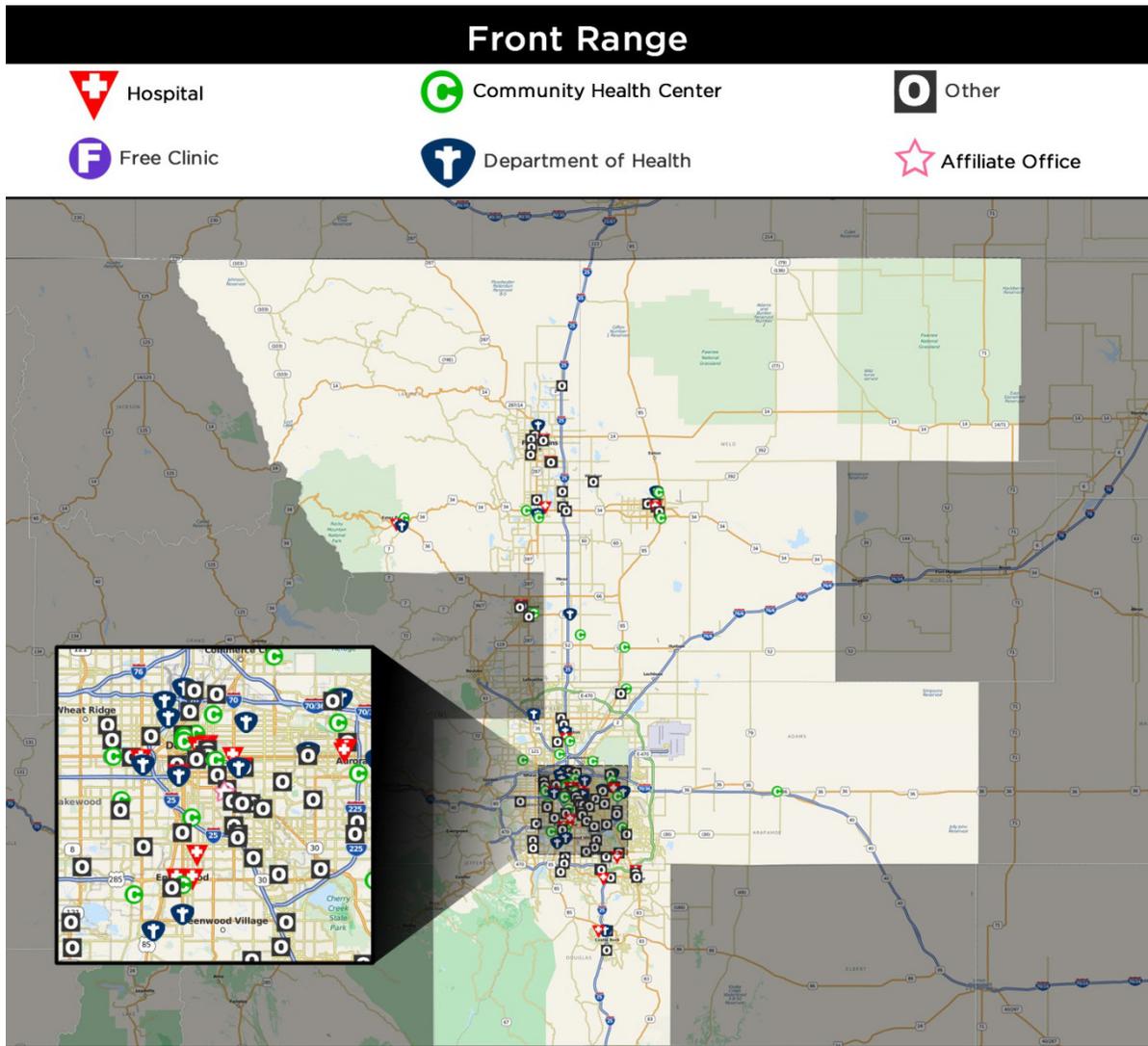


Figure 3.5. Breast cancer services available in Front Range counties

Public Policy Overview

National Breast and Cervical Cancer Early Detection and Treatment Programs

Colorado’s National Breast and Cervical Cancer Early Detection Program (NBCCEDP) is administered through the Colorado Department of Public Health and Environment (CDPHE)’s Prevention Services Division as the Women’s Wellness Connection (WWC). Women aged 40-64 years old, with family incomes below 250 percent of the federal poverty level, who meet state residency requirements, are uninsured or underinsured, and who have not had a mammogram within the last 12 months are eligible for enrollment in WWC. This includes male-to-female transgender individuals who have taken or are taking hormones and female-to-male transgender individuals who haven’t undergone a complete hysterectomy or bilateral mastectomy (Women’s Wellness Connection, 2014).

The program is funded through a combination of federal funds from the US Centers for Disease Control and Prevention NBCCEDP budget and state funding from revenues generated by a tax levied on tobacco products under a 2004 constitutional amendment. CDPHE contracts with

health care providers using a grant-based model to allocate funds for clinical services and care coordination across the state.

As of WWC Fiscal Year 2012-13, which ended June 29, 2013 and the most recent full year for which data were available, WWC screened 21.4 percent of an estimated 79,816 uninsured women aged 40-64 under 250 percent FPL (Table 2.10). There were wide variances in screening percentages within the Affiliate service area, from four percent in Sedgwick County (located in rural northeast Colorado) to 47 percent in Gilpin County (considered a Mountain and resort community). Each year, WWC determines whether funds should be reallocated from providers unable to meet screening benchmarks to providers with demonstrated capacity to screen.

As of this writing, WWC screening services were available at 130 locations through 43 agencies. Of those, 79 clinics are located within the Affiliate's service area. Broomfield, Clear Creek, Park, Phillips, and Sedgwick Counties have no WWC provider. Eligible Coloradans can find a local WWC provider using a hotline, online map, or through regional staff contracted through the American Cancer Society.

With the expansion of Medicaid eligibility to 133 percent of the federal poverty level in Colorado, WWC has reported a decrease in enrollment of eligible individuals into the program through the end of the second quarter of 2014 compared to the same period in prior years. Projections indicate up to 75 percent of Colorado's previously WWC-eligible population now is Medicaid-eligible. WWC has carried out a multi-phased strategic planning process to identify options to increase screening percentages and WWC enrollment among the remaining eligible population of women. As of this writing, a final determination has not been made, but options include:

- increasing the number of WWC providers throughout the state
- lowering the age of eligibility from 40 to 21 for cervical cancer screenings
- providing technical support to enhance existing WWC providers' electronic health records to improve screening percentages and in-reach programs and
- partnering with Medicaid and other insurance providers to increase screenings among newly insured populations.

Women who meet the WWC age and income eligibility requirements who have been diagnosed with breast cancer and certain pre-cancerous conditions are eligible to receive treatment through Colorado's Medicaid Breast and Cervical Cancer Treatment Program (Medicaid BCCP). Medicaid BCCP is administered through the Colorado Department of Health Care Policy and Financing (HCPF), which administers all Medicaid programs. Women in Colorado who meet all eligibility criteria may enroll in Medicaid BCCP regardless of location of diagnosis. Previously, women could only enroll in Medicaid BCCP if they had been diagnosed through a WWC provider. Enrollment in Medicaid BCCP occurs through county health departments, which process applications for all Medicaid programs. Women also must meet HCPF's requirements for residency and creditable coverage to enroll in the program.

With Colorado's implementation of Medicaid expansion effective in January 2014, women diagnosed with breast cancer also are screened for Medicaid eligibility prior to being enrolled in Medicaid BCCP. As a result, Medicaid BCCP has reported a lower-than-normal newly-enrolled caseload through June 2014. Despite this decline, the Affiliate, CDPHE and HCPF anticipate ongoing need for the program for newly diagnosed women who are uninsured and earn less

than 250 percent of the federal poverty level but too much to qualify for Medicaid. While this demographic of women likely would qualify for premium assistance and tax subsidies to purchase private health insurance through Colorado's health care exchange, there will be uninsured women who will be diagnosed with breast cancer outside of the annual open-enrollment windows or, if diagnosed during the open-enrollment period, will be exempt from the federal requirement for individuals to purchase health insurance.

Komen Colorado worked with HCPF and CDPHE to protect Medicaid BCCP by extending the program through June 2019 during the 2014 Legislative Session. In addition to reauthorizing the program, the legislation passed in 2014 codifies the least-restrictive enrollment option to allow any otherwise eligible woman to enroll regardless of the location of diagnosis and simplifies the revenue sources used to comprise the state's responsibility for the program. Like WWC, Medicaid BCCP is funded through a combination of federal and state dollars, with the federal government paying \$1.86 on every state dollar invested in the program. State funds come from a combination of existing revenues in the Medicaid BCCP cash fund and new dollars generated through a fee assessed for breast cancer-awareness license plates.

The Affiliate maintains a strong working relationship with WWC and Medicaid BCCP staff, meeting at least quarterly with the managers of each program. In addition, WWC and Medicaid BCCP staff participate in bimonthly conference calls with chairs of the Affiliate's regional breast health coalitions. This increases communication, transparency, and alignment of operations and priorities between WWC, Medicaid BCCP, Komen Colorado, the Affiliate's grant recipients, and other breast health care stakeholders. The Affiliate anticipates sustaining these relationships to maintain its strong working relationship with both programs.

State Comprehensive Cancer Control Coalition and State Cancer Plan

The Colorado Cancer Coalition (CCC) is undergoing organizational transition. During this transition, the Coalition continued its core activities, including connecting individuals and organizations active in the state's cancer community, disseminating information of interest to members, coordinating updates to the state cancer plan, and publishing the state's first all-cancer resource directory (the successor to the long-standing Colorado Breast Cancer Directory funded in part by the Affiliate). Headquartered in Denver, CCC convenes quarterly member meetings with call-in capabilities to facilitate remote participation. The Affiliate is a member of the Coalition, serves on the Coalition Restructure Committee, and participates in meetings of the Breast Cancer Task Force (BCTF), one of 11 volunteer-based task forces responsible for coordinating efforts to achieve objectives identified in the state cancer plan.

According to the 2010-2015 Colorado Cancer Plan published by the Colorado Cancer Coalition, the following breast cancer objectives were identified:

- By 2015, increase to 80 percent the proportion of women aged 40 and older reporting that they received a mammogram in the past two years. According to 2012 BRFSS data, just 68.5 percent of women aged 40-74 reported receiving a mammogram in the past two years.
- By 2015, increase to 98 percent the proportion of women who complete diagnostic evaluation of breast findings in 60 days or less. According to WWC, the April 2014 CDC Core Performance Indicators Report for Colorado said that as of June 2013, 96.0 percent of diagnostic evaluations of breast findings were completed in 60 days or less.

- By 2015, support the development and implementation of survivorship care plans. As of this writing, the Affiliate did not receive an update on progress made toward this objective.

Preliminary drafting of the 2016-2020 Colorado Comprehensive Cancer Plan has begun, with the plan set for release in early 2015. Komen Colorado is on the BCTF's sub-committee responsible for developing objectives specific to breast cancer. Komen Colorado will continue to be an active member of CCC and BCTF. Although it has been approached by CCC leadership to serve on CCC's Public Policy Task Force, the Affiliate's limited staff capacity prevents it from doing so, which raises concerns about whether Komen Colorado's public policy priorities will be integrated into CCC's policy efforts.

Implementation and Effects of Affordable Care Act within Affiliate Service Area

All major components of the Affordable Care Act (ACA) were or had been implemented as of this writing. Those expected to have the most substantial impact on access to breast health care services for the target communities identified by the Affiliate are discussed below based on three broadly defined anticipated outcomes:

1. Decrease in Colorado's Uninsured Population
2. Expansion of Scope of Coverage for Insured Individuals
3. Change in How Health Care Is Delivered and Paid For Locally

In addition, through mid-2014, the Affiliate compiled anecdotal reports from grant recipients, allied community-based organizations, and WWC indicating full ACA implementation was having an effect on the underinsured population, as well. Overall, the Affiliate anticipates these changes in Colorado's health care marketplace will alter local community need for financial and public education/outreach support from Komen Colorado.

Decrease in Colorado's Uninsured Population

Historically, the Affiliate has used its Community Grants program to invest 75 percent of net revenues in local nonprofit health care clinics, hospitals and community-based organizations to offset costs for breast cancer screening, diagnosis, and treatment for Colorado women and men earning less than 250 of the federal poverty level who are uninsured or underinsured. The Affiliate considers someone underinsured if their insurance did not cover their breast cancer care or if individuals' co-pays or co-insurance responsibilities were cost-prohibitive. Changes in the number of uninsured or underinsured Coloradans will affect need for these Affiliate resources.

Three core provisions of ACA are reducing the number of Coloradans who are uninsured:

- The state expanded Medicaid eligibility up to 133 percent of the federal poverty level for all lawfully present adult Coloradans, regardless of parenting or dependent status. Unlike private insurance, enrollment in Medicaid is available continuously.
- Colorado launched a state health insurance marketplace, Connect for Health Colorado, where individuals can purchase qualified health insurance plans. Private insurance plans can be purchased through annual open-enrollment periods or if individuals experience qualifying life-change events (Connect for Health Colorado, 2013).
- Federal law allows individuals earning between 134 percent and 400 percent of the federal poverty level to receive financial assistance to offset how much they pay for premiums, co-pays, co-insurance and deductibles for private health insurance plans.

Combined, these three provisions are projected to reduce the number of uninsured Coloradans by 53.4 percent from 860,000 to 400,000 by 2016 (Gruber, 2011). Gruber anticipates the composition of the remaining uninsured will be:

- Undocumented individuals who are ineligible to purchase private health insurance plans through the marketplace or to enroll in publicly funded health care programs including Medicaid, Medicaid BCCP, and the Colorado Indigent Care Program (CICP) – 39 percent
- Documented individuals who either aren't required to have health insurance (29 percent) or who choose not to purchase insurance (22 percent)
- And newly uninsured individuals – 10 percent

While these are statewide projections, the Affiliate anticipates similar changes in insurance coverage status across the 22 counties within its service area.

To understand initial changes in insurance coverage status, Komen Colorado evaluated preliminary enrollment data following the close of the first open-enrollment period between October 1, 2013, and April 15, 2014. Statewide, approximately 355,000 people enrolled in health insurance in Colorado, of which 254,000 – or 71.5 percent of statewide enrollments - were in the Affiliate's 22-county service area. According to April 2014 data from Connect for Health Colorado, 122,000 enrolled in private health insurance plans on the marketplace statewide; 94,600 of those were in the Affiliate service area (representing 77.5 percent of statewide enrollments). Analysis of monthly caseload data from HCPF indicates 233,000 individuals were newly enrolled in Medicaid; the Affiliate service area saw 159,800 Medicaid enrollments (68.6 percent of statewide enrollment).²

Data in Table 3.5 indicate enrollments as a percentage of county population were reasonably consistent throughout the Affiliate service area. The largest number of enrollments in 2014 occurred in the counties with the largest populations: Denver, Arapahoe, Jefferson and Adams. With the exception of Douglas and Pitkin Counties, most counties experienced larger enrollments in Medicaid than in private insurance.

Limitations with these estimates include the fact that the population of new enrollments does not precisely indicate the number of newly insured. The figures could overestimate new coverage because people with prior private insurance may have purchased new coverage on Connect for Health Colorado to access the financial assistance available to offset costs for premiums and deductibles, including people with pre-existing conditions like breast cancer survivors who previously were insured through the state's high-risk pools. The newly insured may be over-estimated because data are unavailable quantifying the number of individuals who did not pay their premiums and/or dropped private coverage within the first few months after purchase.

² This represents total new enrollments between October 1, 2013 and March 31, 2014. Not all changes in enrollment may be related to the ACA.

Table 3.5. Enrollment figures for private plans and Medicaid after 2013-14 open enrollment period

Area	2013 Population (1)	Total Enrolled 10/1/13-4/14/14: Connect for Health Colorado Private Health Insurance		Total Enrolled 10/1/13-4/14/14: Medicaid		Total Enrolled 10/1/13-4/14/14: Connect for Health Colorado and Medicaid	
		Number of Individuals (2)	Percentage of Population	Number of Individuals (3)	Percentage of Population	Number of Individuals	As Percentage of Population
Komen Colorado Service Area	3,777,065	94,568	3%	159,828	4%	254,396	7%
Adams	467,666	8,721	2%	23,258	5%	31,979	7%
Arapahoe	604,398	15,707	3%	25,652	4%	41,359	7%
Boulder	308,954	10,254	3%	10,972	4%	21,226	7%
Broomfield	58,913	1,702	3%	1,571	3%	3,273	6%
Clear Creek	9,005	203	2%	406	5%	609	7%
Denver	649,481	15,675	2%	37,386	6%	53,061	8%
Douglas	303,339	7,055	2%	5,582	2%	12,637	4%
Eagle	53,811	1,596	3%	1,665	3%	3,261	6%
Garfield	58,724	1,026	2%	2,493	4%	3,519	6%
Gilpin	5,562	164	3%	255	5%	419	8%
Jefferson	549,643	13,857	3%	20,041	4%	33,898	6%
Larimer	302,783	8,227	3%	13,689	5%	21,916	7%
Logan	22,276	385	2%	896	4%	1,281	6%
Morgan	28,571	405	1%	1,133	4%	1,538	5%
Park	16,527	518	3%	822	5%	1,340	8%
Phillips	4,373	137	3%	201	5%	338	8%
Pitkin	17,498	1,571	9%	541	3%	2,112	12%
Sedgwick	2,390	59	2%	119	5%	178	7%
Summit	28,970	1,068	4%	875	3%	1,943	7%
Washington	4,650	145	3%	169	4%	314	7%
Weld	269,386	5,788	2%	11,717	4%	17,505	6%
Yuma	10,145	305	3%	385	4%	690	7%

Sources: (1) Colorado Demography Office. (2) Connect for Health Colorado. (3) Colorado Department of Health Care Financing and Policy Medicaid Client Caseload by County Reports. Note: Newly enrolled may have been previously insured in private or public insurance; therefore, enrollment figures may overestimate newly insured.

A July 2014 report published by The Commonwealth Fund estimates that nationally, 59 percent of people who gained private insurance coverage through health insurance exchanges were previously uninsured at the time of application. The Commonwealth Fund estimates that 66 percent of Medicaid enrollees were previously uninsured. However, new enrollments do not include people who may have enrolled in individual or employer health insurance outside of the Connect for Health marketplace. The Commonwealth estimates were used to calculate estimated decreases in numbers of uninsured individuals throughout the Affiliate service area in Table 3.6.

Table 3.6. Estimated decrease in numbers of uninsured individuals since 2012

Area	Uninsured Individuals in 2012 (1)	Estimated Newly Insured Individuals who Were Previously Uninsured (assumes 59% of Connect for Health private plans and 66% of Medicaid enrollees were previously uninsured)	Newly Insured as Percentage of 2012 Uninsured Population
Komen Colorado Service Area	522,762	138,961	27%
Adams	85,954	20,496	24%
Arapahoe	91,710	22,114	24%
Boulder	31,382	10,625	34%
Broomfield	5,481	1,599	29%
Clear Creek	771	335	43%
Denver	106,414	29,848	28%
Douglas	19,222	6,012	31%
Eagle	7,803	1,626	21%
Garfield	12,834	1,984	15%
Gilpin	462	222	48%
Jefferson	62,015	17,800	29%
Larimer	38,173	11,750	31%
Logan	3,080	718	23%
Morgan	3,819	881	23%
Park	2,196	713	32%
Phillips	602	178	30%
Pitkin	2,564	875	34%
Sedgwick	323	98	30%
Summit	4,185	930	22%
Washington	653	159	24%
Weld	41,757	9,643	23%
Yuma	1,362	355	26%

Source: (1) Colorado Health Institute Analysis of the American Community Survey Retrieved

Understanding changes in insurance coverage among women aged 40-64 – the demographic that Komen Colorado grants have primarily supported – is more difficult because data about private plans were not available specific to that demographic as of this writing. However, anecdotal reports from breast health providers and requests for assistance placed to the Affiliate have identified the following gaps in insurance coverage:

- Uninsured women over age 40 below 250 percent of the federal poverty level who fall into two sub-populations: (a) those eligible to purchase private insurance, with financial assistance, but choose not to due to financial hardship, are exempt from the requirement to have insurance, or other reasons; and (b) those ineligible to purchase private insurance due to immigration status.
- Underinsured women below 250 percent of the federal poverty level who cannot afford co-pays, deductibles, or other out-of-pocket expenses.

The latter group is difficult to quantify, but the former can be estimated comparing rates of uninsured women aged 40-64 with household incomes less than 250 percent of the federal poverty level in 2012 against 2014 rates. Based on these data, the Affiliate calculated an estimated population of remaining uninsured women aged 40-64 below 250 percent of the federal poverty level based on the 2012 uninsured population and Medicaid enrollment figures as of March 31, 2014 (Table 3.7).

Table 3.7. Estimate of remaining uninsured women aged 40-64 below 250 percent federal poverty level ineligible for Medicaid, Women’s Wellness Connection or Medicaid Breast and Cervical Cancer Treatment Programs

Komen Colorado Service Area***	Rural Northeast Colorado	Resort and Mountain Counties	Front Range Counties
22,878	876	2,141	15,830

Estimates based on assessment of change in uninsured population below 400% FPL between 2012 (accessible via the Small Area Health Insurance Estimates released by the US Census Bureau) and April 2014 (Connect for Health Colorado and Colorado Medicaid).

*The Affiliate assumed 100% of Medicaid-eligible population below 138% FPL had been enrolled, leaving the population of remaining uninsured women below 138% FPL as of March 31, 2014, ineligible for the program. This could be an overestimate.

**The Affiliate assumed 40% of the remaining uninsured women 40-64 years old between 138-250% FPL would be eligible to enroll in the Women’s Wellness Connection and Medicaid Breast and Cervical Cancer Treatment programs based on Gruber’s estimate that 60% of the remaining uninsured population in 2016 will be undocumented and therefore ineligible to enroll in WWC or BCCP.

*** Population in Affiliate Service Area is greater than sum of geographic target community populations due to inclusion of women in counties not included in target communities (i.e., Boulder, Gilpin & Jefferson). The Affiliate did not calculate estimates for remaining uninsured Hispanic/Latina populations because of expectations that the numbers calculated by the geographic-based target communities include Hispanic/Latina women.

Using the figures from Table 3.8, the Affiliate used call-back and diagnostic rates for breast cancer detection from the American Cancer Society to estimate the annual minimum cost for breast cancer screening, diagnostic, and treatment for the remaining uninsured population within its service area to be nearly \$4.6 million, assuming the following:

- The entire population follows the screening protocol from Komen messaging to receive annual screening mammograms
- 10 percent of women are called back for diagnostic mammograms
- 8 percent of those women need invasive biopsies
- 20 percent of biopsies result in a breast cancer diagnosis

Table 3.8. Estimated annual costs of breast cancer screening, diagnostics and treatment for remaining uninsured population of women aged 40-64 below 250 percent Federal Poverty Level within Affiliate service area

Community	Number of Uninsured Women	Total Cost: Screening Mammograms	Total Cost: Diagnostic Mammograms	Total Cost: Biopsies	Total Cost: Treatment	Annual Total Direct Care Costs
Resort and Mountain Communities	2,141	\$299,711	\$59,942	\$15,157	\$54,804	\$429,615
Rural Northeast Colorado	876	\$122,646	\$24,529	\$6,202	\$22,427	\$175,805
Front Range Counties	15,830	\$2,216,210	\$443,242	\$112,077	\$405,250	\$3,176,779
Affiliate Service Area - Total	22,878	\$3,202,958	\$640,592	\$161,978	\$585,684	\$4,591,212

NOTE: Rates used to calculate expenses based on the following: treatment expenses based on Colorado Fiscal Year 2011 rate of \$16,000 per breast cancer case for Medicaid BCCP clients. Rates for screening mammograms (\$140), diagnostic mammograms (\$280) and biopsy (\$885) are the rates used by WWC for its bundled payment system effective June 2013.

The Affiliate anticipates these costs are low because of the Medicaid BCCP treatment figure. For more accurate and updated figures, the Affiliate would need true costs of care charged by payer type for all breast cancer-related procedures performed in the 22-county service area, which is available at a cost through Colorado’s all-payer claims database (APCD) administered by Colorado’s Center for Improving Value in Health Care (CIVHC; see discussion below).

It is important to note that a portion of the population of uninsured women aged 40 and older won’t be able to access health insurance coverage due to their immigration status. Federal and state laws prohibit undocumented individuals and legal permanent residents with fewer than five years of residency from enrolling in publicly funded health insurance programs and from purchasing private insurance through health care exchanges. As a result, uninsured women in the Affiliate service area who fall into those categories cannot be enrolled in Medicaid, WWC, Medicaid BCCP, Medicare, or the Colorado Indigent Care Program – leaving Komen Colorado as the primary source to offset financial barriers to breast cancer care.

Unfortunately, accurate counts for of this population are difficult to determine. To estimate the potential need for Affiliate resources to serve this demographic, Komen Colorado extrapolated from national figures published by the US Census to apply to its service area. According to 2010 US Census data, approximately one in five residents of Hispanic/Latino origin are not US citizens (18 percent for women; individuals of Hispanic/Latino origin comprise the majority of foreign-born individuals in Colorado). Census data estimate that 105,200 Hispanic/Latina-identifying women aged 40-90 lived in the Affiliate Service area in 2010 (Colorado Demography Office). If 18 percent of these women aren’t US citizens, then 18,900 Hispanic/Latina women age 40 and older within the Affiliate’s service area could be ineligible for breast health insurance coverage through the above resources. The potential annual financial demand for the Affiliate to use its Community Grant program to pay for screening, diagnostics, and treatment care for this population is estimated at \$3.8 million. It is important to note that this figure reflects all income levels.

Overall, the implications of the increase in covered individuals for CoC providers throughout the Affiliate service area is still being determined and will be assessed through qualitative assessments. However, a June 2014 analysis from the Colorado Health Association comparing

patient-payment sources from the first quarter of 2013 to the first quarter of 2014 found “urban, rural and critical access hospitals (CAHs) all [experienced] ...increases in Medicaid volume and decreases in self-pay volume and charity care....Across the state, total Medicaid charges for Colorado grew 37 percent, while total self-pay charges dropped by 27 percent.” This parallels preliminary findings among WWC agencies, which reported increases in their Medicaid client populations in 2014 (Lawrence, 2014).

Of concern to the Affiliate is whether there are sufficient providers to serve newly insured patients. For previously uninsured patients newly enrolled in Medicaid, the Affiliate is particularly concerned about whether newly insured women in all four of the Affiliate’s target communities who previously relied on Komen grant support to enter/move along the CoC will be able to identify local breast health surgeons, radiologists and oncologists who accept Medicaid. The Affiliate also questions whether newly uninsured women who purchased private plans have sufficient health insurance literacy to identify in-network providers and meet their co-payment, coinsurance and deductible responsibilities to self-navigate through the CoC in their community. The Affiliate anticipates exploring these questions through the qualitative assessment to determine whether women who previously entered or moved along the CoC because of Komen grant support are now at risk of falling out of the CoC.

Expansion in Scope of Coverage for Insured Individuals

Under the ACA, health insurance companies can price plan premiums based on four rating criteria: geographic location, age, family size, and smoking status. Given that increased age is a risk factor for being diagnosed with breast cancer, the use of age as a rating criterion adversely affects uninsured women who might seek out private coverage but find it too cost-prohibitive relative to their income and overall cost of living. The Colorado Department of Regulatory Affairs (DORA) established 11 geographic rating areas for insurance carriers to set premiums rates for 2014, of which six were in the Affiliate service area.

In 2014, an analysis by the Kaiser Family Foundation found that one of the regions the encompasses counties with mountain and resort communities had the highest premiums nationwide without tax credits and cost-sharing reductions to offset consumers’ out-of-pocket expenses. After applying financial assistance, a *Denver Post* analysis found the region that includes the Denver-metropolitan area had the highest premiums (2014). Both regions are within the Affiliate service area. Based on anecdotal reports from organizations that had been awarded grants by the Affiliate through June 2014, the Affiliate anticipates seeing increases in the number of underinsured women from geographic rating areas with comparatively higher costs for private insurance, especially for women in the Affiliate’s mountain and resort target community.

The increase in underinsured individuals with private insurance potentially increases the cost of breast cancer care covered by the Affiliate’s community grant program because of patients’ inability to meet their co-insurance, deductibles, and other out-of-pocket expenses for care. Because health care providers bill for health care costs according to patients’ source of payment, the amount charged to patients with private health insurance could be higher than the amount charged to individuals covered by WWC and Medicaid BCCP. Komen Colorado’s grant recipients must agree to charge no more than the WWC and Medicaid BCCP rates for breast cancer care. The Affiliate currently does not have data about the variance in rates charged by payment source. Accurate costs of care charged by payer type for all breast cancer-related

procedures performed in the 22-county service area is available at a cost through the APCD administered by CIVHC.

If the Affiliate allows its grants to cover privately insured patients' deductibles and co-insurance costs, some of which may be higher than the WWC and/or Medicaid BCCP rates, the cost to the Affiliate to provide financial support to underinsured individuals is expected to increase.

To reduce variances in rates across the state, the Colorado Division of Insurance (DOI) sought federal approval to consolidate rating areas from 11 to nine in 2015. Analysis by DOI indicates premiums will decrease by more than 7.4 percent in Glenwood Springs, which falls in the rating area that includes the mountain and resort communities. However, premium costs are expected to increase by 5.3 percent, 4.6 percent and 0.8 percent in Fort Collins, Greeley and Denver, respectively - all cities located within the Front Range target community (2015). It is too early for the Affiliate to determine the geographic distribution of need for Affiliate support for underinsured individuals.

The ACA instituted insurance reforms that apply to most individual and group health plans and were to be fully implemented by January 1, 2014. However, to ease the transition for individuals and insurance carriers, the President and DOI have allowed individuals to renew individual and small group "non-qualified"³ health plans through 2015. These non-qualified plans cannot be purchased through the Connect for Health Colorado marketplace. All plans sold on the marketplace are qualified health plans that include the following required health insurance reforms:

- Inclusion of coverage for 10 essential health benefits (Colorado Division of Insurance, 2014) with scope of coverage based on the benchmark plan selected by DOI in 2012 (US Centers for Medicare and Medicaid Services Center for Consumer Information and Insurance Oversight, 2014). The scope of required coverage for women includes screening mammograms every one to two years for women at normal risk for breast cancer and, for women with higher risk for breast cancer, genetic testing/counseling and chemoprevention counseling; these preventive services must be covered without co-pay or other cost-sharing requirements (Healthcare.gov, 2014).
- Coverage for other preventive health services and screenings without cost-sharing.
- Limitations on individuals' cost-sharing responsibilities for co-pays, co-insurance and deductibles (out-of-pocket maximums).
- Guaranteed availability and renewability of coverage.
- Ban on denying coverage or determining premium costs based on pre-existing conditions or individuals' health status.
- Prohibition on plans' imposing lifetime or annual limits on coverage.
- Non-discrimination in health care.
- Coverage for clinical trial participants.
- Modified community rating, which limits health insurance plans' determinations for premiums to be based only on age, geographic area, tobacco usage and family size.

Per federal law, the essential health benefits of coverage for plans sold through Connect for Health Colorado may change beginning with the 2017 plan year. Komen Colorado anticipates the state's Division of Insurance, which has regulatory authority over private insurance plans in

³Non qualified health plans do not meet all the ACA requirements such as providing all the essential health benefits, guaranteed renewability, no lifetime or annual limits on coverage and modified community rating.

the individual and small-group markets, will begin assessments of adequacy and perceived gaps in coverage beginning in 2015.

For the nearly 30,000 women over age 35 in Komen Colorado’s service area that purchased private health insurance plans on the marketplace, these insurance reforms will improve access to recommended breast health screenings and improve access to coverage for women with past history of breast cancer. Women receiving breast cancer treatment will no longer be subject to lifetime and annual limits on coverage.

Health plans sold on the market place are organized in four coverage levels so they would be comparable. The four coverage levels are denoted as metal tiers, and are based on actuarial value which is basically the percentage of expenses paid by the health plan (Table 3.9).

Table 3.9. Individual co-insurance responsibilities by plan type and distribution of plans purchased – 2014 Plan Year

Coverage Level	Percentage of average expenses paid by health plan	Percentage of average expenses paid by consumer	Percentage of Colorado Consumers selecting coverage level*
Bronze	60%	40%	40%
Silver	70%	30%	46%
Gold	80%	20%	10%
Platinum	90%	10%	1%

*Source: US Department of Health and Humans Services, Office of Assistant Secretary for Planning and Evaluation. Retrieved 5/5/2014 at: <http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/pdf/co.pdf>

The out-of-pocket maximums imposed under the ACA are important protections against consumer debt and bankruptcy. To help offset out-of-pocket expenses to consumers, there are two types of financial assistance available who purchase marketplace plans. There is premium assistance to consumers with incomes between 133 and 400 percent of the federal poverty level. The Kaiser Family Foundation has estimated that 59 percent of Colorado marketplace consumers received financial assistance to purchase plans and the average monthly assistance was \$196. Consumers may apply the premium assistance to any of the metal tier plans. The assistance is provided on a sliding scale and is based upon the consumer’s annual income.

Additional assistance is provided for consumers with incomes between 133 and 250 percent of the federal poverty level. This assistance is provided through cost-sharing-reduction plans (CSRs) that offer reduced deductibles, coinsurance and co-payments to qualified consumers. However, CSRs are only available to qualified consumers who purchase a silver plan, which means the 40 percent of marketplace consumers who purchased bronze plans may face higher out-of-pocket costs than silver CSR plan purchasers. Data are not yet available on the portion of the silver plan consumers who purchased CSR plans.

Despite these financial assistance options, anecdotal reports from Komen Colorado grant recipients, WWC, and other community stakeholders indicate patients earning between 134 to 250 percent of the federal poverty level with private insurance have struggled to meet their deductible and co-pay responsibilities in 2014. Total out-of-pocket costs to consumers vary based on the coverage level purchased. The 40 percent of Coloradans that purchased bronze plans appear to have selected policies with lower relative premiums but higher deductibles compared to the other plan tiers. For healthy women this may be cost-effective. However,

breast cancer patients undergoing active treatment and those following up on adjuvant therapy likely will accumulate bills quickly totaling the \$6,350 out-of-pocket maximum required by the bronze plans. There is greater variance in the deductibles and coinsurance for the silver plans. Projected total out-of-pocket expenses for 60 year-olds – the average age when women are diagnosed with breast cancer within the Komen Colorado service area – are summarized below. (Table 3.10).

Table 3.10. Estimated out-of-pocket expenses for a 60-year-old breast cancer patient based on level of commercial insurance coverage – 2014 Plan Year

Expense Type	Bronze	Silver	Gold
Monthly premium (range)	\$395-\$647	\$521 to \$727	\$606 to \$1,121
Combined annual medical and drug deductible (range)	\$4,500-\$6,300	\$1,250 to \$6,100	\$0 to \$3,000
Coinsurance for services like chemotherapy after patient pays deductible (range)	0 percent to 50 percent of rate negotiated between insurance care and provider	0 percent to 40 percent of rate negotiated between insurance care and provider	\$150 co-pays for imaging plus 35 percent of rate negotiated between insurance care and provider for radiation or chemotherapy
Total range of out-of-pocket expenses	\$11,090 to \$14,114	\$10,118 to \$15,074	\$10,772 to \$17,452
Expenses for platinum plans not calculated due to the relatively small market share. Expenses calculated by reviewing insurance plan documents for policies sold in Denver.			

Remaining out-of-pocket expenses contribute to a perceived increase in the number of underinsured individuals citing co-pays, deductibles, and co-insurance as barriers inhibiting women in all of the Affiliate’s target communities from moving seamlessly along the CoC. As a result, the Affiliate should evaluate its capacity to allocate financial resources to offset these cost-related barriers to breast cancer care.

Change How Health Care Is Delivered and Paid For Locally

There are a number of other initiatives in the ACA to increase access to health care through increasing the number and diversity of the health care workforce, strengthening the health care safety net and developing models that improve the quality of patient care. Each of these initiatives could affect women’s ability to access breast cancer care locally, or when necessary, be referred across different health care systems or regional care collaboratives to access breast cancer specialists. Komen Colorado has included discussion of key initiatives that could affect (a) how the Affiliate’s Community Grant Program is administered and (b) how local non-profit health clinics, hospitals, and community-based organizations that provide access to the CoC adapt their business models to remain viable as initiatives transform the state’s health care landscape.

Colorado has forged ahead with pilot projects to evaluate delivery and payment reform initiatives. These initiatives are designed to find new models of care that improve on the fragmented delivery system that dominates the US health care system, such as the fee-for-service model that reinforces the use of high-volume, expensive care like surgeries and expensive imaging. Historical preference to pay providers for addressing sick patients has reduced the availability of funds for preventive health care and care management. Many of the pilot initiatives underway in Colorado are exploring new delivery models that focus on providing

more accessible, integrated and coordinated care and payment reform models that focus on paying for care coordination and cooperation among providers. These projects could have implications for the Affiliate's target communities to access breast health and breast cancer care.

Although there are no published delivery or payment reform pilots specifically directed toward women with breast cancer in Colorado, there are a number of programs focused on care coordination that benefit women with cancer. In fact, a number of breast cancer treatment centers employ care coordination through patient navigation programs. The discussion below briefly summarizes reform efforts underway that may potentially improve preventive health care and breast cancer care for women.

Patient-centered medical homes (PCMH) are one of the foundations of health care system changes. The PCMH is a care delivery model where the patient has a personal, long-term relationship with a primary care physician (or similarly qualified provider) where the focus of care is to keep the patient healthy. There are a number of programs that recognize and/or accredit health care organizations as medical homes. The most commonly referenced program in Colorado is the National Committee for Quality Assurance (NCQA). The Center for Improving Value in Health Care (CIVHC) estimates that in 2011, 567 of the estimated 3,500 primary care physicians in Colorado had achieved PCMH recognition from NCQA.

Of concern to the Affiliate is whether wait times at PCMH providers have increased for newly insured patients who do not have an established primary care provider. This is a concern because historically medically underserved individuals within the Affiliate's target communities are, by definition, less likely to have a primary care physician or similarly qualified provider. While organizations that have received grants from the Affiliate have established protocols to expedite scheduling for new patients who present with breast abnormalities, women without breast symptoms may be put on a waiting list to become an established patient. The latter situation has been reported by organizations that have received Komen Colorado grants to provide breast self-awareness messaging and navigate rarely/never screened patients into the breast health continuum of care.

The Affiliate also is sensitive about whether PCMH providers that receive grant funds to offset costs of breast cancer care are considered "in-network" providers for newly insured individuals who are underinsured. If a Komen Colorado grant recipient is not an in-network provider, access to Affiliate-funded financial support remains out of reach.

Like PCMHs, care-coordination and care-transition programs aim to improve the patient experience, in this case by reducing hospital readmissions by coordinating care from one provider to another. Usually, this is from the hospital to home. Two examples that could have a direct impact on the target communities within the Affiliate service area include:

- Longmont Community Health Network: This is a two-year project to provide in-home care to uninsured/underinsured patients with chronic conditions. Paramedics provide in-home care along with assistance from Longmont United Hospital, Mental Health Partners, Boulder County Public Health and the Salud, Kaiser, Longmont, NextCare and Hopelight clinics. Given the prevalence of co-morbidities among Affiliate-eligible breast cancer patients in the geographic region served by LCHN partners, breast cancer could be considered an eligible chronic condition. (Multiple partners in this project either are

current or former Affiliate grant recipients or have applied for Affiliate funding.) The Affiliate should find out whether LCHN has breast cancer-specific lessons learned through this project.

- Saint Anthony Hospital/Centura Reconnect Leadership Project: This project connects patients with a coach prior to leaving a hospital. Retired professionals are trained as volunteers to provide care coordination in the hospital and to facilitate communication with patients, hospital associates, and physicians. As a current grant-receiving organization of the Affiliate and a provider that accepts patients from all of the Affiliate's target communities, Saint Anthony can act as a resource for the Affiliate to understand the degree to which this project benefits breast cancer patients.

Bundled payment is a model that provides a single payment to a provider, or group of providers, for health care services associated with a specific episode of care. For example, for a bundled payment for a knee replacement, payments would cover a defined span of time from the hospital admission through weeks of rehabilitation. If the patient is readmitted to the hospital during that time, the provider must absorb the cost. According to CIVHC, savings are shared with the providers when the cost of care is less than would have been in the traditional fee for service system (2012). Like the two care-coordination and -transition projects above, one bundled payment pilot is being tested by a current Komen Colorado grant-receiving organization. SCL Health System's Saint Joseph Hospital, which provides screening, diagnostic and treatment care for breast cancer, is participating in a Medicare Acute Care Episode bundling demonstration program for cardiac surgery. The Affiliate can leverage its existing relationship with Saint Joseph to determine whether any processes and outcomes from the pilot have the potential to be replicated for breast cancer patients. The Affiliate also is sensitive to the use of a bundled payment model by the Women's Wellness Connection because the Affiliate historically has used WWC payment rates to cap payments for breast health services.

Global payment is a model where providers or provider organizations are paid prospectively for the care of a patient or a group of patients for a period of time. Payments are adjusted to reflect the health status of the patient. Global payment programs include incentive payments for meeting preventive and quality care standards. Provider organizations that meet the standards and provide efficient, coordinated care without expensive hospital readmissions are able to retain a portion of the savings.

Rocky Mountain Health Plans (RMHP) is a regional care collaborative organization (RCCO) in the western part of Colorado that borders the Affiliate's western-most boundary (where residents of the mountain and resort target community are located). Komen Colorado has an opportunity to understand how patients who travel out of the Affiliate service area into RMHP's service area to access breast cancer care are affected by this model. One question the Affiliate should explore is whether the Affiliate would need to adjust the rates or payment structures of grant-receiving organizations that serve mountain and resort residents in the western region of the Affiliate service area to match RMHP's global payments to ensure providers agree to serve Komen-funded patients.

Against the backdrop of pilots in payment models and decreasing numbers of uninsured Coloradans, Komen Colorado should investigate changes to the private health care funding landscape that could affect overall community need for continued Affiliate investment. Anecdotal

reports within Colorado's health care funding community indicate funders are re-evaluating their priorities to determine how to allocate resources toward direct services, health systems change, incentivizing changes in patients' health care decision-making, and other related issues. For safety-net clinics that act as the primary care provider for medically underserved populations, a reduction in funding to support direct services could destabilize agencies' operations – threatening their ability to continue providing services, including well-women visits that include clinical breast exams, breast health education, and referrals for screening mammograms. For community-based organizations that provide community health workers/promotoras de salud, decisions to expand health systems funding could enable those organizations to identify hard-to-reach, medically underserved communities. By understanding changes in Colorado's private health funding landscape, the Affiliate can better target its resources and avoid duplicating funding priorities that are supported by other philanthropic organizations.

Finally, the Affiliate will determine how to maximize a new tool aimed at increasing transparency around health care costs in Colorado. The Colorado APCD administered by CIVHC contains medical claims, which are requests for payment to health care insurers. They are created and submitted by medical providers (e.g., physicians, labs, pharmacies, hospitals) after the provider delivers a health care service or product to a Colorado patient who is covered by the insurer. Under Colorado law, all insurers must forward a copy of every claim, after it is processed, to CIVHC. CIVHC started collecting claims in 2009 and has expanded its payer base over time.

Medical claims contain codes that indicate medical diagnoses and treatment, medical provider (hospital, physician or other medical professional), lab services, pharmacy prescriptions filled, and personal medical equipment such as hearing aids and crutches. They also contain the amounts paid by patients and by their insurance carriers for each service or item provided (i.e., the total, final payment or full cost of care).

Analysis of this information enables consumers, organizations and researchers to determine several factors that could improve patient and population health, the quality of health care, and costs. Komen Colorado could use the APCD to analyze costs of care across the CoC by geographic area or by facility, for example, to better understand costs of breast cancer care throughout its service area. This information in turn will help the Affiliate forecast anticipated expenses for breast cancer services funded through its Community Grant program based on which providers apply for and are awarded grant funding. Because the cost to obtain custom reports from the APCD ranges from \$5,000 to \$10,000 apiece, the Affiliate should partner with allied stakeholders to assess feasibility of cost-sharing to access cancer- or breast-cancer-specific reports.

Affiliate's Public Policy Activities

Komen Colorado maintains a public policy committee to prioritize and provide direction for the Affiliate's engagement on state and local policies that affect access to breast health care services. In determining whether to support policies, the Affiliate has considered whether policies are consistent with Komen's mission of saving lives, ensuring quality care for all, and energizing science to find the cures. The Affiliate's public policy recent engagement at the state level have included both issues identified by Komen as national priorities as well as issues to expand and protect access to breast care:

- 2014: Secure reauthorization of the state's NBCCEDP Treatment Program (Medicaid BCCP) and allow license plate fees to fund the program

- 2013: Support Medicaid expansion to 133 percent FPL
- 2013: Secure temporary funding to treat women through BCCP regardless of location of diagnosis
- 2012: Lobby for coverage of clinical trials, orally administered anti-cancer medications to be covered at the same level as intravenously administered drugs, and other critical cancer care as essential health benefits in Colorado's benchmark plan for health insurance plans certified to be sold through the state exchange
- 2010: Support health insurance plans to providing parity of coverage for anti-cancer medications regardless of whether they are delivered intravenously or orally
- 2010: Support requiring mammography as a covered benefit in individual and small-group health insurance plans
- 2009: Add \$25 fee to optional breast cancer-awareness license plates to generate revenues to cover costs of treatment for women diagnosed at non-WWC locations

Through its legislative history, the Affiliate has developed relationships with state and local elected officials and is considered an expert on breast health care policy within the state. In 2014, the Affiliate partnered with American Cancer Society to host a legislative briefing on hot topics in cancer policies, which allowed Komen Colorado to educate elected officials about the importance of continuing Medicaid BCCP. The Affiliate also invites state legislators to attend site visits and regional coalition meetings.

The Affiliate also maintains relationships with in-district health policy, constituent outreach, or legislative staff for the six members of congress that represent Komen Colorado's service area (CD 1, CD 2, CD 3, CD 4, CD 6 and CD 7) and the state's two US Senators. The Affiliate has positioned itself as a local expert for national elected officials on breast health care issues, annually providing members with the Affiliate's Community Grant list and legislative briefs on changes in state laws that affect access to screening, diagnostic and treatment for breast cancer. Specific to Komen's 2014 federal policy priorities of Medicaid expansion, coverage for oral anti-cancer medications, protecting federal and state funding for NBCCEDP, and ensuring continued federal investment in breast cancer research through the National Institutes of Health (NIH), National Cancer Institute (NCI) and Department of Defense (DOD), the Affiliate works with Komen's Advocacy Team to determine which members of Colorado's Congressional Delegation could benefit from in-district meetings to ask for support on FY15 appropriations bills.

Future Opportunities

Based on analyses of changes in Colorado's health care system and anecdotal reports from Komen Colorado grant-receiving organizations during the first six months of 2014, the Affiliate anticipates the need to engage on a number of issues to increase access to breast health care within the Affiliate service area. Priorities include:

- Reviewing essential health benefits to ensure full coverage of all necessary breast services for screening, diagnosis, treatment and survivorship care, such as:
 - Secondary screenings in the event of abnormal mammogram
 - Lymphedema sleeves, wigs, and other non-medical/pharmaceutical needs to address side effects of breast cancer treatment
 - New and emerging pharmaceuticals included in the state prescription drug list and each metal tier of private insurance

- Tracking allied organizations' development of protocols and standards of care regarding patient and physician education about dense breast tissue, genetic testing and counseling, and related patient privacy protections
- Examining state and federal restrictions that limit eligibility for Medicaid, WWC, BCCP and individuals' ability to purchase private health insurance plans
- Removing the sunset date from BCCP to enable program to continue into perpetuity
- Securing funding for breast cancer research

In addition to leveraging its existing public policy committee, the Affiliate should consider the following to promote its public policy priorities:

- Join existing health policy coalitions that focus on consumers, medically underserved Coloradans, and individuals living with chronic conditions to ensure the needs of breast cancer patients are reflected in shared policy priorities. Existing coalitions and organizations to join include Colorado Consumer Health Initiative, Colorado Chronic Care Collaborative, and Colorado Coalition for the Medically Underserved.
- Carry out targeted education efforts among medically underserved communities to increase health insurance literacy around breast health care coverage.
- Expand the Affiliate's grassroots advocacy capacity to build a network of breast cancer patients, survivors, providers and community stakeholders who will act as liaisons with state and federal elected officials.

Health Systems and Public Policy Analysis Findings

The Affiliate identified health care providers and community-based organizations that provide services along the breast cancer continuum of care for each of the target communities. While each geographic target community had providers along the continuum of care, proximity to facilities emerged as a consistent potential barrier to care for individuals who lived in rural northeast Colorado, mountain and resort communities, or more rural or medically underserved parts of Front Range counties. As a result, the Affiliate noticed consistent responses from providers located within Front Range counties along the major transit corridors indicating that they served patients who had traveled from counties other than where the providers' facilities were located. In addition, a mobile mammography unit operated by Denver-based SCL Saint Joseph Hospital has provided mammography screening to both rural northeast Colorado and the western-most counties where mountain and resort communities are located.

Due to the age and maintenance needs of the unit, it is unknown whether this mobile unit will continue to be available to increase access to screening in these regions going forward. The two other mobile mammography units that operate within the Affiliate's service area either are limited to providing care only within the boundaries of the City and County of Denver (Denver Health) or only accept patients with insurance (University of Colorado Health). The Affiliate will explore how factors associated with having to travel for care – such as securing time off from work, transportation, lodging when treatment inhibits same-day return to where patients live, and in some cases, child care – may exacerbate distance as a barrier to breast cancer care.

Each geographic target community also indicated providers who serve Hispanic/Latina populations, indicating that existence of providers for that target community is not a barrier. In addition, the majority of those providers indicated that Spanish-language support is available, mitigating the potential concern that a lack of native-language medical information about breast

cancer could be a barrier for Spanish-speaking Hispanic/Latina populations. Through the qualitative data section of this report, the Affiliate anticipates exploring other potential barriers to care, including the known gap in health insurance coverage among Hispanic/Latino adults in Colorado, immigration status, and cultural differences in attitudes about breast cancer.

While providers that serve each of the Affiliate's target community indicated they accept Medicaid, the Affiliate is concerned about anecdotal reports from its current grant recipients and its partners within the Medicaid BCCP program and broader chronic care community that specialty providers have stopped accepting new Medicaid patients because of relatively low reimbursement rates to provide patient care. A substantial number of women below 138 percent of the federal poverty level who previously received breast cancer care through Affiliate grants or WWC are now enrolled in Medicaid, so the reported lack of facilities willing to accept new Medicaid patients could have an adverse effect on breast health outcomes throughout the Affiliate service area.

Within all target communities, potential new partnerships include for-profit imaging centers and surgical centers that partner with Komen grant recipients for screening, diagnostics and breast surgery. Federally qualified health centers, free clinics and nonprofit clinics that serve as medical homes and entry points for breast cancer education and screening are potential mission partnerships. Community-based organizations, such as, literacy programs, senior centers, and immigrant rights programs, are potential mission partners to provide breast health education.

With the implementation of health care reform, the Affiliate has seen a decrease among some previously uninsured populations who used Komen Colorado grant funds for breast cancer care but now are eligible for enrollment in Medicaid or to receive financial assistance to offset costs to pay for private insurance. However, the Affiliate also has seen an increase in individuals that purchased private insurance but struggle to pay their co-pays or deductibles, demonstrating that cost continues to act as a barrier for that population, although the point at which cost becomes a barrier has shifted from the screening mammogram to diagnostic procedures. In addition, some populations that have historically relied on Affiliate grant funds to cover costs for breast cancer care have not experienced any change in need for Komen Colorado support, such as undocumented women and men, women younger than age 40 who earn too much for Medicaid but cannot be enrolled in WWC or Medicaid BCCP, and women earning 138-250 percent of the federal poverty level who are exempt from having insurance.

The Affiliate will continue to engage with its partners in the broader cancer and chronic care communities to collaborate on public policy solutions to increase the scope of health insurance coverage for screening, diagnostic, treatment, and survivorship care for breast cancer. The organization also will continue to evaluate how pilot projects aimed at changing how health care is delivered and paid for – through regional care collaborative and other health care financing models – affects women at risk for breast cancer and breast cancer patients in each of the Affiliate's target communities.

Qualitative Data: Ensuring Community Input

Qualitative Data Sources and Methodology Overview

Qualitative data for Komen Colorado's Community Profile were gathered with the assistance of Corona Insights, a Denver-based market research and strategic consulting firm. Corona Insights has extensive experience conducting community needs assessments, and provides expertise in both quantitative and qualitative research. Two research methods were selected to explore breast health needs in the Affiliate's four target communities. First, an online survey of breast health providers was conducted, followed by in-depth interviews with providers.

A number of factors contributed to the Affiliate's selection of these two research methods for each target community, including:

- Breast health providers throughout the Affiliate service area have expertise about patients' challenges accessing and utilizing breast cancer care in local communities.
- Based on estimates of the number of uninsured women aged 40-64 under 250 percent of the federal poverty level within the geographic-based target communities that could benefit from Affiliate-funded breast cancer care (19,228 within seven Front Range counties, 2,380 within six mountain and resort communities, and 980 within six rural northeast Colorado counties), the Affiliate determined it had insufficient resources to conduct enough focus groups to gather statistically sufficient data. Because the Affiliate expects a substantial portion of target communities located within geographic regions to be Hispanic/Latina, sample-size sufficiency requirements also made focus groups of Hispanic/Latina women cost-prohibitive.
- Lacking contact information of women aged 40-64 under 250 percent of the federal poverty level who have not entered the breast cancer continuum of care, the Affiliate did not have capacity to use random-sample surveying to gather insight from medically underserved individuals.

The key questions and variables that were assessed with each research method were (barriers to) access and utilization of services along the breast cancer continuum of care. The use of an online survey of staff at health clinics, hospitals, and community-based organizations that provide services along the breast health continuum of care allowed the Affiliate to identify themes in barriers to care within each target community. Key informant interviews with breast cancer care providers allowed the Affiliate to understand nuances of the top barriers that were identified and solicit providers' suggestions to overcome the barriers using methods they believe would be most appropriate for the target community they serve. Each research method is described in detail, below.

Survey of Breast Health Providers

Methodology

An online survey of breast health providers was conducted to assess provider resources, practices, and needs, focusing in particular on the breast health needs of women who experience adverse social determinants of breast health, as defined by race/ethnicity, poverty, insurance, and cultural factors. The survey also captured differences among target communities. The survey instrument was designed via collaboration between Corona Insights and Komen Colorado after conducting a joint review of the Quantitative Data Report and Health Systems Analysis to confirm target communities for the study and to identify areas to explore in

greater depth with qualitative research. Findings from focus groups of breast cancer patients conducted by the Colorado Breast Cancer Coalition and key information interviews conducted by the Women’s Wellness Connection also informed survey design. A survey was selected as the initial tool for research because this enabled the Affiliate to reach out to all providers of health care and support services in the service area and efficiently gather a great deal of input on a relatively large number of topics including: services provided, resources available, patient populations served, barriers to each stage of care, experiences, and role in their community’s breast health care system. Survey routing and skip patterns were used to ask questions or not ask questions based on responses to earlier questions such that respondents were not presented with redundant or irrelevant questions. The tools allowed the Affiliate to ask more detailed questions in each area based on each respondent’s unique situation. The survey length was approximately 15-20 minutes for each participant.

The survey instrument was administered as a secure, online survey using Snap Survey Software. Corona Insights programmed and tested the survey. The Affiliate sent an advance email announcing the survey and requesting participation. The survey invitation and reminder emails were sent by Corona Insights. The survey ran from July 17, 2014, through August 4, 2014, with two reminder emails sent during the survey period to all who had not yet responded nor opted out of the survey. As an incentive, survey respondents were offered complimentary registration to either Race for the Cure Aspen or Race for the Cure Denver.

Sampling

The Affiliate provided a list of all known providers of breast health services or support in their service area compiled from the Health System Analysis. All known providers were invited to participate in the survey, which included 251 individuals from 166 organizations. Responses were received from 116 individuals from 92 organizations (Table 5.1). A weighting system was developed to correct for multiple responses from a single organization so that each organization had equal weight in the survey relative to the number of locations through which breast cancer services were delivered. The margin of error for results is approximately ±6.8 percent at a 95 percent confidence level.

Table 5.1. Number of organizations from each target community that responded to online survey

	Number of Organizations
Serve +20% Rural NE Patients	26
Serve +20% Resort Mtn Patients	19
Serve Front Range Counties	75
Serve +20% Hispanic Patients	36

***Some organizations were categorized into more than one of the target communities based on the type of patient population that they serve.*

Ethics

Survey participation was voluntary, and survey respondents could skip questions or opt out of the survey at any time. Survey respondents were not anonymous and respondents provided both the name of and their position within the organization, which allowed us to identify responses from multiple respondents within an organization (often multiple people responded from an organization and each provided responses to different topics based on their roles within

the organization). Survey responses are treated as confidential, and individual respondents are not linked to their responses in this, or any, report of results.

Interviews with Breast Health Providers

Methodology

One-on-one telephone interviews were conducted with breast health providers from each target community to gather in-depth information on several key issues identified by the survey. In particular, the interviews explored barriers to breast health screening, diagnosis, and treatment, and proposed solutions to remove barriers. Interviews focused on unique needs within each target community including financial barriers, knowledge barriers, documentation status, and transportation barriers.

The interview guide was designed via collaboration between Corona Insights and the Affiliate, after conducting a joint review of the survey findings to identify areas to explore in greater depth with follow-up research. Telephone interviews were selected as the method for follow-up to best accommodate the schedules of busy professionals while gathering needed in-depth detail about barriers and potential solutions in each community. The interview length was approximately 30-40 minutes for each participant.

The Affiliate conducted the recruiting and scheduling of interviewees through multiple phone call attempts and by e-mail. Potential interviewees were selected from the database of breast health providers developed through the Health Systems Analysis.

Interviews were conducted by two Corona Insights staff and two Affiliate staff. To minimize potential bias, Corona Insights staff interviewed individuals from organizations that currently receive or recently received grant funding from the Affiliate. Affiliate staff interviewed individuals from other types of organizations. Interviews were conducted between September 29, 2014, and November 6, 2014. In all 54 interviews were conducted, a 98.2 percent response rate.

Sampling

The organization attempted to identify a diverse range of provider types, including current/recent grant recipients, organizations that do not receive grant funds from the Affiliate, for-profit organizations that serve target communities, and nonprofit entities that serve target communities. The Affiliate attempted to interview at least three providers per county in each of the geographic target communities (Mountain and resort, rural northeast, and Front Range). Where interviewees served multiple counties or more than one geographic target community, the interviewee was prompted to identify differences based on counties served. Some counties in the rural northeast and Mountain and Resort communities did not have three breast care providers, so the Affiliate attempted to interview all breast providers in those counties as identified through the Health Systems Analysis. The Affiliate attempted to interview at least 12 providers that self-identified as serving Hispanic/Latina patients through the Health Systems Analysis and self-identified Hispanic/Latina patients as a patient demographic in the online survey. There was substantial overlap with providers identified for geographic-based target communities. Where a provider had self-identified provision of services to both geographic-based target communities and Hispanic/Latina patients (e.g., serves patients from Mountain and Resort communities and Hispanic/Latina populations), the Affiliate counted that provider toward the goal of three providers per county and one of 12 providers to serve Hispanic/Latina patients. In those instances, the interviewer modified the script to evaluate needs/barriers specific to each target community served by the provider (Table 4.2).

Table 4.2. Number of key informants interviewed for each target community

	Number of Interviews	Serve Large Hispanic Population
Rural Northeast	12	8
Resort/Mountains	14	10
Front Range/Statewide	28	21
Total	54	39

Ethics

Interview participation was voluntary, and participants could skip questions or opt out of the interview at any time. Interview responses are treated as confidential, and individual respondents are not linked to their responses in this, or any, reports of results.

Qualitative Data Overview

Survey responses were collected electronically using the Snap Surveys online survey platform. Data collected from the online survey were analyzed using Snap 11 Professional survey analysis software, for tabulation and cross-tabulation of responses.

Interview responses were typed by the interviewer during the interview. Notes were organized by interview question to facilitate analysis. Thematic analysis was conducted by coding themes identified in the prior survey research and also themes that arose from the interview data.

Survey Findings

One of the intentions of the survey was to identify key differences between target communities that would then be probed further in the interviews. One of the biggest differences between communities was the types of barriers that breast health patients faced at different points in the continuum of care. Thus, further exploration of those barriers became the primary objective of the interviews. These barrier differences, along with other findings unique to each of the target communities, will be discussed in each region's section. In the current section, only broader, overarching findings that emerged from the survey will be described.

The top three breast health and cancer services offered by providers throughout the Affiliate service area were patient navigation, education about breast health/health care generally, and patient support and follow up, as these services were provided by both health care facilities and community-based organizations. Of those providing patient support and follow up, the most common services provided were financial assistance and counseling services. The least common service was childcare while receiving services. Among health care providers, more than half reported that their patient navigators were required to attend training for patient navigation.

The most common mammography guideline used by providers was a mammogram every year starting at age 40. The second most common guideline was informed decision-making with a health care provider for ages 40-49, then mammography every 2 years for ages 50-74. Differences in the screening guidelines used by different organizations may be contributing to

the overall confusion about when to get screened, an issue that was heard frequently in the interviews.

Patients who were referred for a mammogram were most often referred to a hospital. For those providers that had mammography on-site, the majority had digital mammography. No one reported having analog technology. Similar to mammogram referrals, diagnostic service referrals were most often to hospitals. When patients were being referred for diagnostic services or treatment, they were traveling on average more than 25 miles. However, estimates for how far patients had to travel on average ranged from 2.5 miles to 200 miles.

Since passage of the Affordable Care Act, providers have noticed an increase in breast health patients with Medicaid and a decrease in uninsured breast health patients. The majority of breast health patients that providers saw were between the ages of 40 and 64 and either non-Hispanic/Latina White or Hispanic/Latina.

To communicate with non-English-speaking patients, providers most often used a full-time translator, written documents, or a tele-translator. When asked about demographic data collected about patients, the majority of providers indicated they either were not currently collecting documentation status information or they did not know whether they were. This is consistent with anecdotal reports to the Affiliate from grant-receiving organizations that information about patients' documentation status is not being collected. (It is worth noting that information about patients' sexual orientation and gender identification also is not collected on a regular basis among grant-receiving facilities, with some facilities' refusing to collect the data unless required by state or federal agencies. Lack of systemic data collection regarding patients' sexual orientation, gender identification, and/or documentation status inhibits Komen's ability to extrapolate breast health trends within these medically underserved populations.)

Almost all providers reported that their organizations discuss with patients their eligibility for financial assistance programs to offset breast health/breast cancer care expenses. However, understanding of how to enroll women into Medicaid BCCP was not high among non-WWC providers. About half of non-WWC providers still believed that a woman must be diagnosed with breast or cervical cancer at a WWC location to be eligible for the program. This suggests an opportunity for the Affiliate to partner more closely with staff from WWC, Medicaid BCCP, and county health departments where BCCP enrollment applications are processed, to train non-WWC providers about the updated Medicaid BCCP eligibility.

Hispanic/Latina Women

The Quantitative Data Report found that Hispanic/Latina women in Colorado have lower screening percentages, and an increasing trend in late-stage diagnosis rates, compared to the population as a whole. These women are also more likely to be low-income (below 200 percent of poverty) and less likely to have insurance than the population as a whole.

The survey findings suggested that immigrant status is a large barrier at all stages of the breast cancer continuum of care. Further, although recent changes in health care have expanded coverage that is not the case for immigrants. In the survey, the top five most common barriers to receiving preventive care were immigrant status, fear of diagnosis and/or treatment, lack of knowledge that screenings are covered without a co-pay or deductible for people with insurance, lack of knowledge about breast health, and lack of insurance. When asked what the

largest barrier was, people were split between immigrant status and lack of insurance (Figure 4.1).

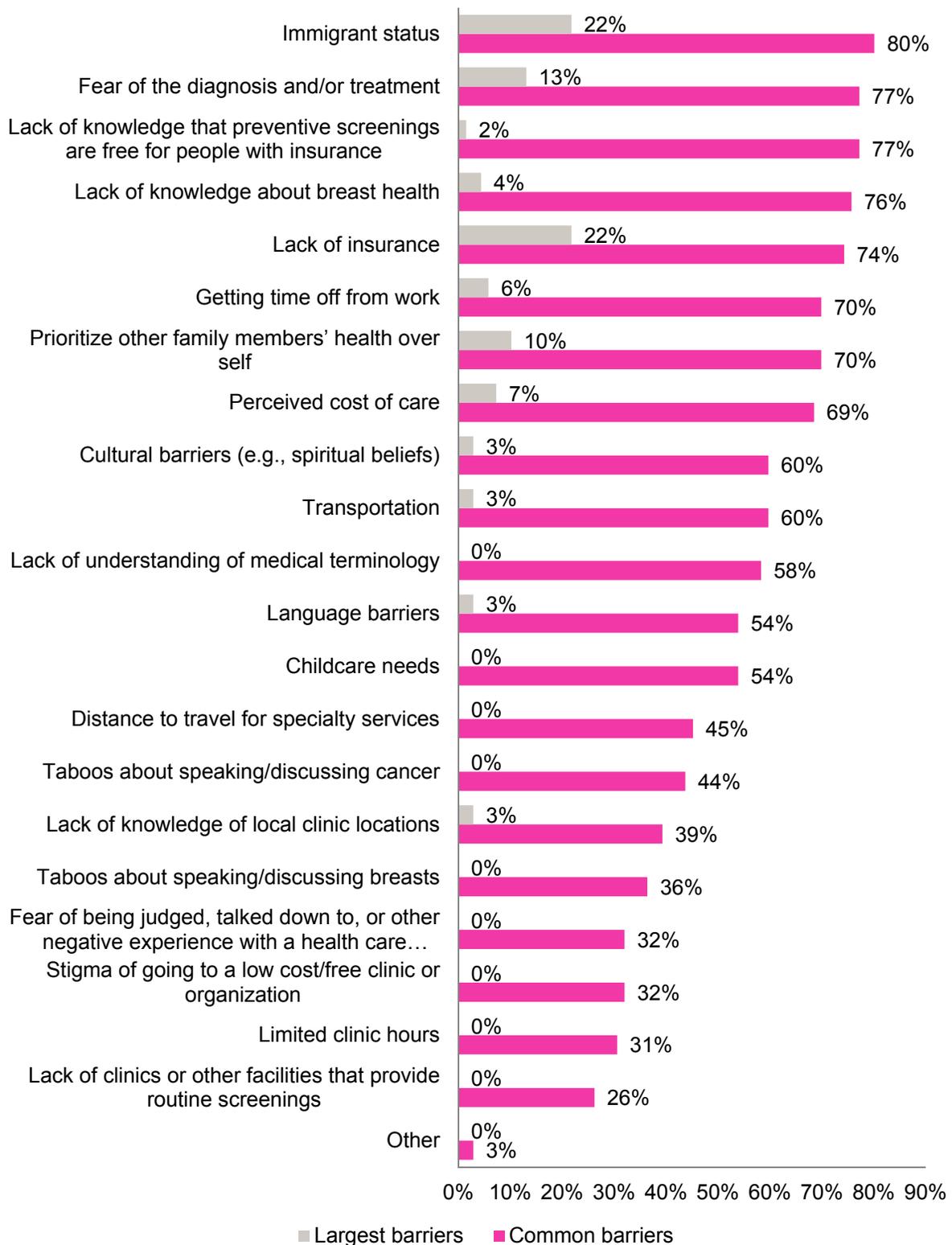


Figure 4.1. Barriers to screening among Hispanic/Latina populations

The top five most common barriers to receiving diagnostic testing were getting time off work, lack of insurance, immigrant status, fear of the diagnosis and/or treatment, and perceived cost of care (Figure 4.2). The three largest barriers were perceived cost of care, lack of insurance, and fear of the diagnosis and/or treatment.

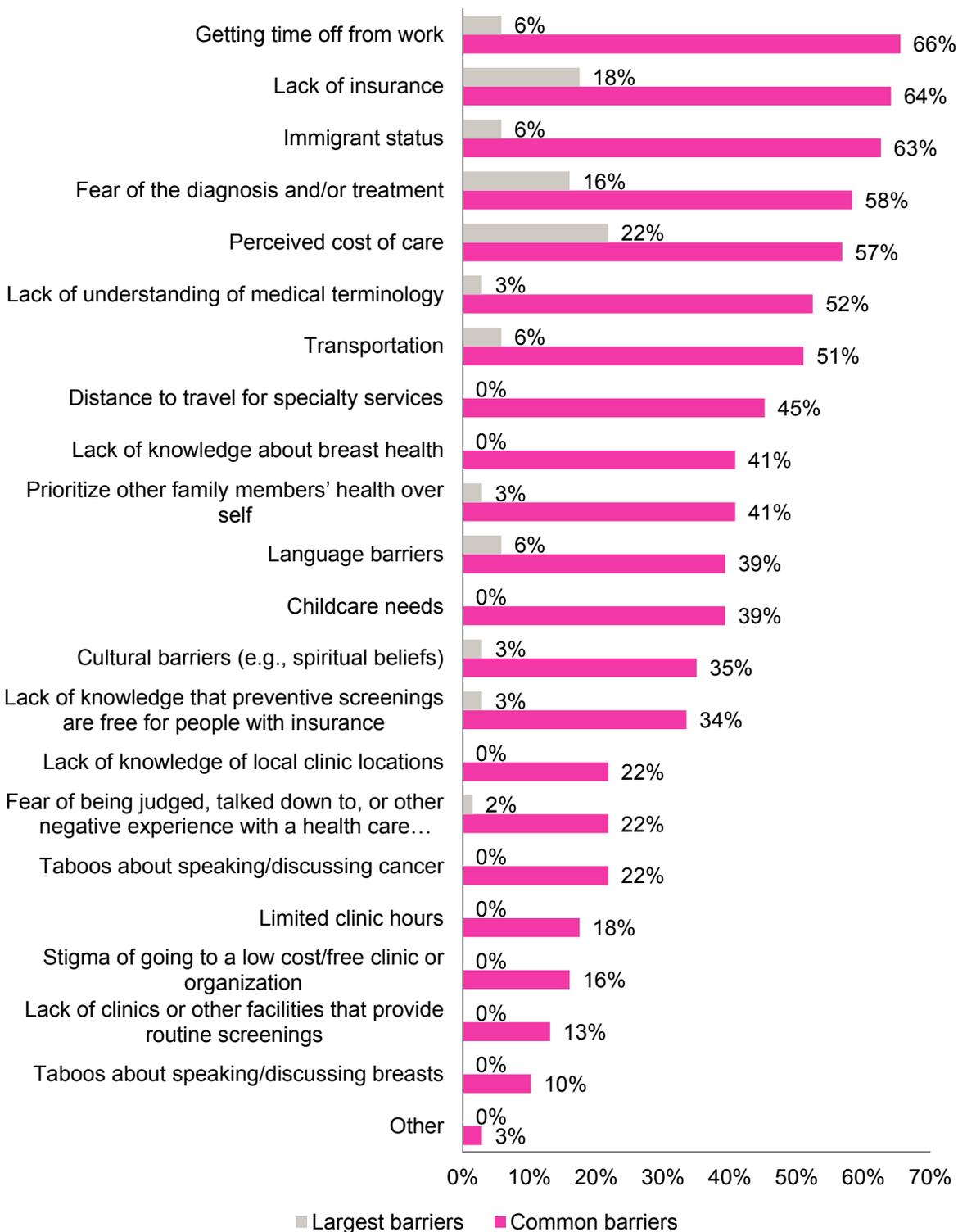


Figure 4.2. Barriers to receiving diagnostic services among Hispanic/Latina populations

The top five most common barriers to receiving treatment were immigrant status, lack of insurance, perceived cost of care, getting time off work, and transportation. The largest barrier was lack of insurance (Figure 4.3).

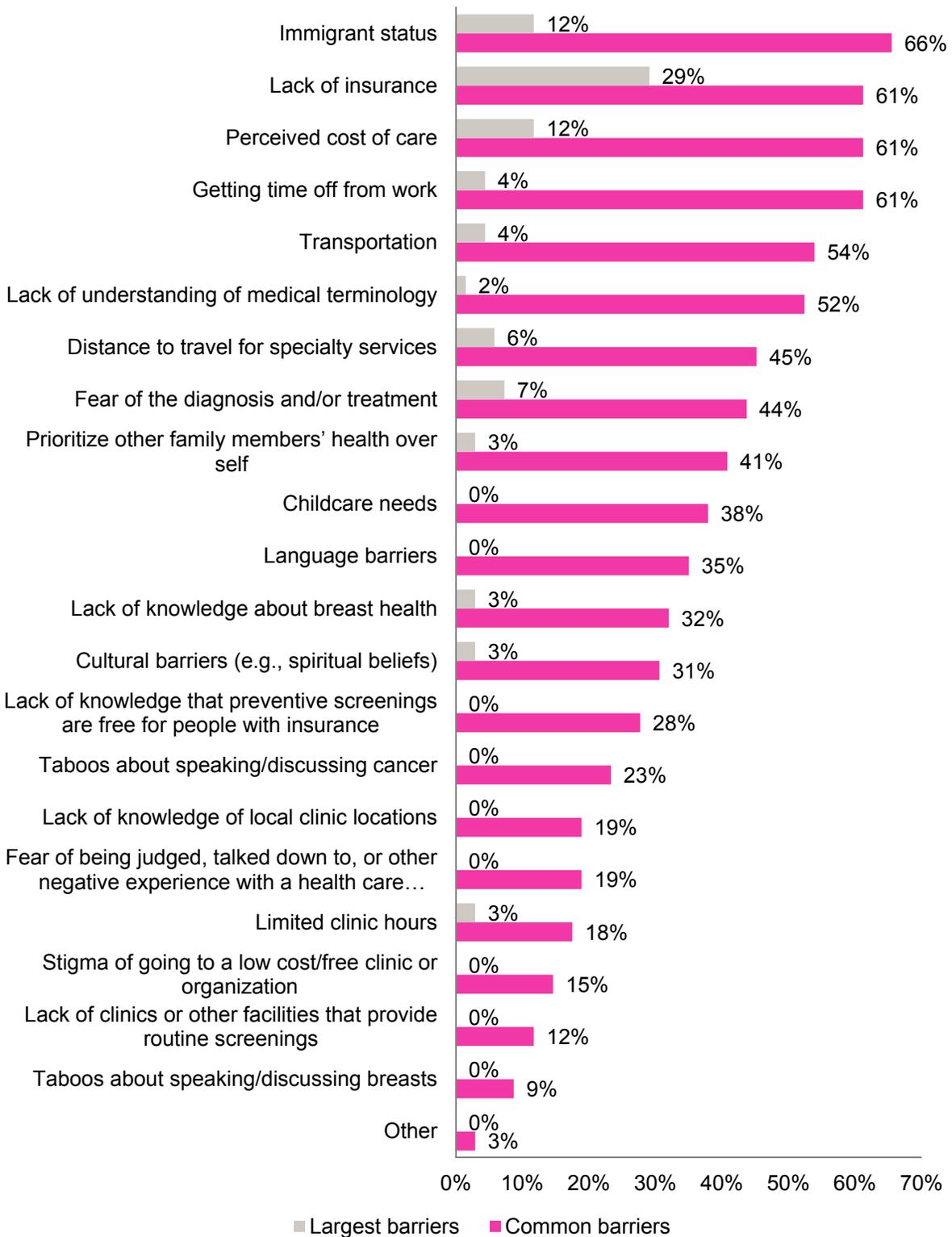


Figure 4.3. Barriers to treatment among Hispanic/Latina populations

Providers serving large Hispanic/Latina populations were the most likely to offer education about breast health/health care generally. Since the passage of the Affordable Care Act, providers serving large Hispanic/Latina populations were the least likely to report an increase in patients receiving breast cancer treatment, which might reflect how immigrant status can interfere with treatment. Providers for large Hispanic/Latina populations also tend to serve large LGBT and foreign-born populations. They were also the most likely to collect documentation status information.

For the most part, providers that serve the rural northeast target community see their Hispanic/Latina population facing the same barriers as everyone else in the region, particularly with regard to difficulties around traveling for care, getting time off for care, and not prioritizing preventive care. For the undocumented, the lack of insurance makes cost a substantial barrier, and two interviewees noted that some undocumented people fear being turned in to immigration if they come to the hospital. Several discussed the language barrier and noted their use of language lines or Spanish-speaking staff as translators. One mentioned concerns with children acting as translators: “A lot bring teenage children to translate. Not sure if we're getting accurate translations. For example, a teenage son doesn't want to discuss his mother's breasts.”

In the mountain and resort region many providers pointed to the need to provide culturally competent care and more navigation for Spanish-speaking patients. Several mentioned that older women in particular seem less comfortable opening up to providers and may not “have a good understanding of how health care works here or why it's important.” It was also explained that for many women, having to call or visit a predominantly Anglo facility was a barrier. Many providers try to quickly route calls to a Spanish-speaker within their organizations, and several had started making follow-up appointments at other facilities for their patients while the patients were still in the office. While many of the providers in this region have bilingual staff, several expressed a belief that this may not be sufficient. One said, “The major barrier is the language. The hospital has an interpreter line, but it is so much better to do it face-to-face with an interpreter. Sometimes not all the staff use [the language line]. The provider/doctor tries to speak some Spanish. The patients don't want to be disrespectful and say they don't understand, but the doctors are practicing [their Spanish] with the patients, and the patients come back here and say they didn't understand.” Another provider indicated that having a Hispanic, Spanish-speaking doctor on staff was making a big difference in bringing in Spanish-speaking patients, just because word of mouth was getting around that this person understood.

In addition to language barriers, a few mountain and resort providers noted a need for better outreach to Hispanic/Latina communities to “get the message out about what Affiliate will pay for and where you can access those services.” One added that messaging needs to be specific, saying, “When they hear, ‘[Komen] can help you,’ you don't understand what can help you.” Several suggestions for outreach were also made. For example, one provider suggested that Spanish-language workshops on breast cancer with Q&A in Spanish could be helpful. Another suggested lobbying big employers (e.g., high-end hotels) to get involved in supporting health initiatives for their employees or sponsoring a community center with resources for their employees.

The mountain and resort region saw additional barriers for undocumented, uninsured residents. As described more thoroughly in the mountain and resort section below, it was explained that it is both difficult to find providers who will accept uninsured patients, and frustrating to navigate

the different paperwork and requirements that different providers require for care, the latter resulting in some providers not accepting patients for screening even though Affiliate grant funds would pay for care. In addition, fears of deportation lead many undocumented patients to forego care because they are unwilling to provide the information necessary to obtain an appointment.

As described in greater detail below, Front Range providers described many of the same barriers as those in the rural northeast and mountain and resort regions, and further emphasized the need for patient navigation to help Hispanic/Latina patients navigate the health care system. As in the rural northeast, many providers pointed to a need for outreach to the Hispanic/Latina community to educate about the need for preventive care and screening, and to introduce available services. As in the mountain and resort community, many described the need for culturally competent care in Spanish. For the undocumented, providers also noted the need to reassure them of safety, which could be accomplished by partnering with trusted community organizations. Many providers praised the use of the mobile mammography van for providing a safe and convenient way to bring services to underserved populations.

Rural Northeast Colorado (Colorado Health Statistics Region 1)

The Quantitative Data Report described the population in this area as older, poorer, and less likely to be insured than in other areas. There is an increasing trend in death rates in this region and screening percentages are relatively low. The Quantitative Data Report raised the issue of limited access to medical facilities as a concern, and concomitant delays in seeking care and transportation barriers.

The survey findings suggested that knowledge was a barrier in this region, especially an early stage barrier that prevented screening (Figure 4.4). Additionally, travel distances came up as a frequent barrier. The top five most common barriers to receiving preventive care were lack of knowledge about breast health, lack of knowledge that screenings are free for people with insurance, immigrant status, lack of insurance, and transportation. There was not a lot of agreement about the largest barrier. The top two choices were lack of insurance and immigrant status.

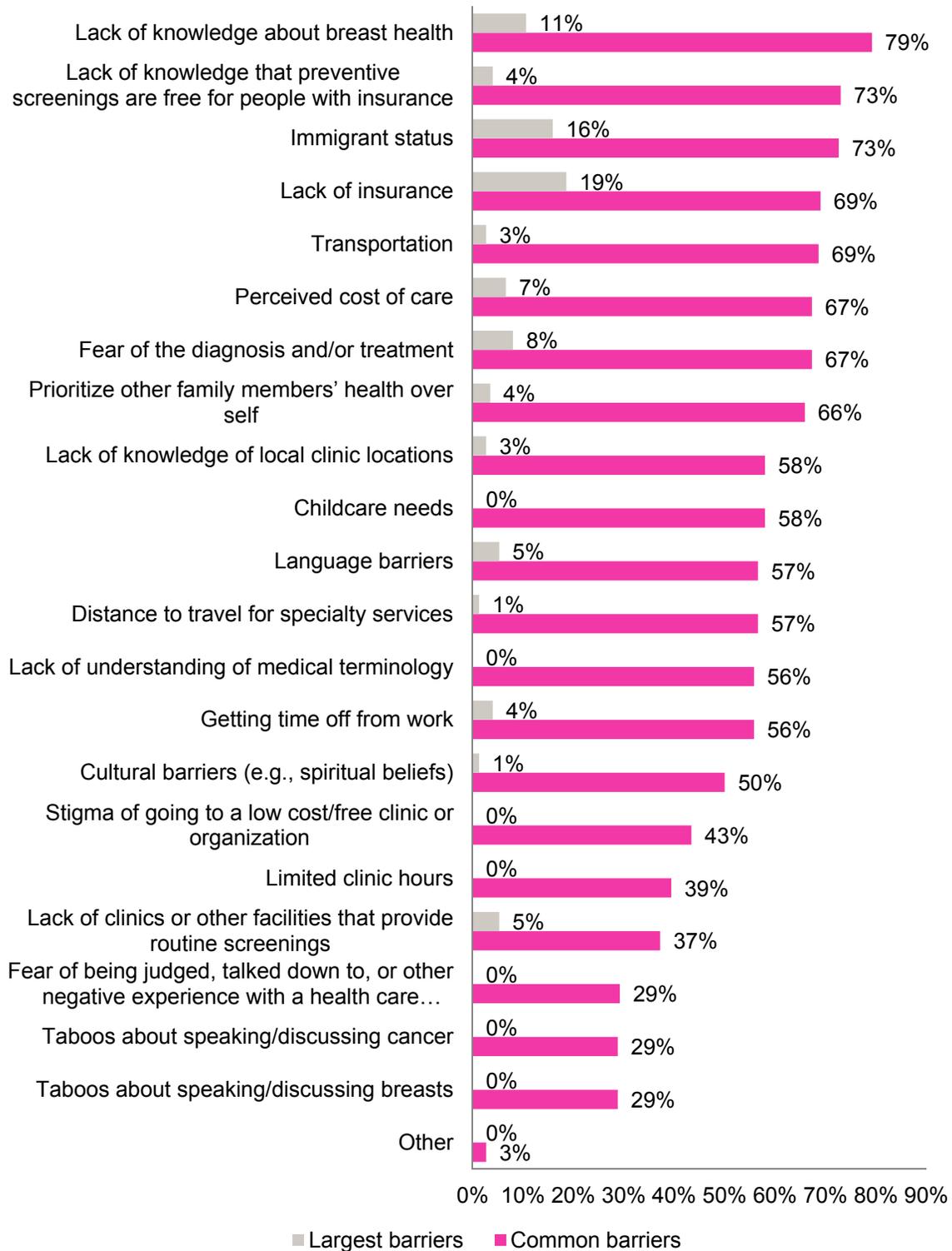


Figure 4.4. Barriers to receiving screenings within rural northeast Colorado

The five most common barriers to receiving diagnostic testing were fear of the diagnosis and/or treatment, lack of insurance, distance to travel for specialty services, immigrant status, lack of understanding of medical terminology, and getting time off from work (Figure 4.5). The three largest barriers were lack of insurance, fear of the diagnosis and/or treatment, and perceived cost of care.

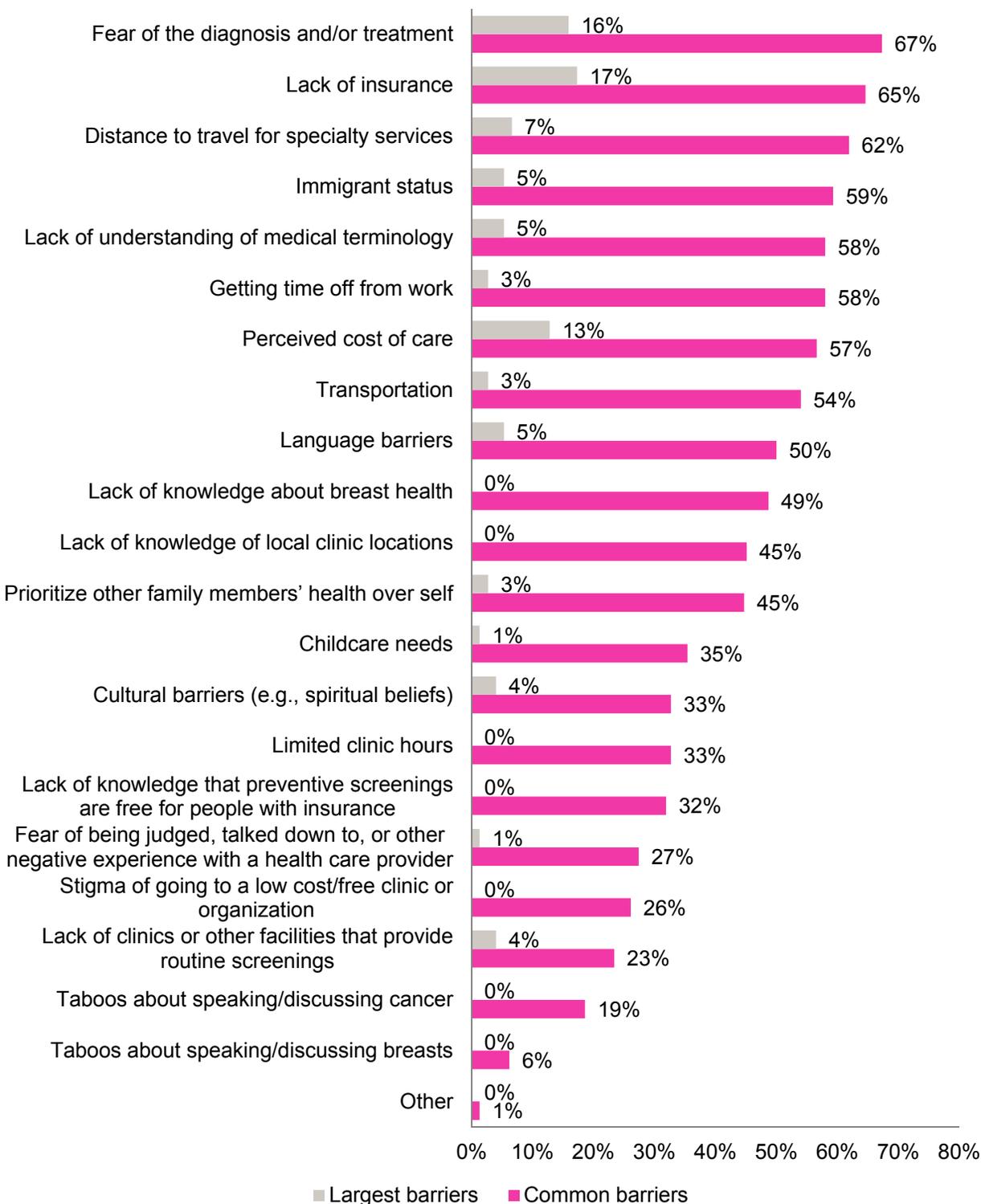


Figure 4.5. Barriers to receiving diagnostic services within rural northeast Colorado

The top five most common barriers to receiving treatment were lack of insurance, immigrant status, perceived cost of care, transportation, and distance to travel for specialty services. The largest barrier was lack of insurance (Figure 4.6).

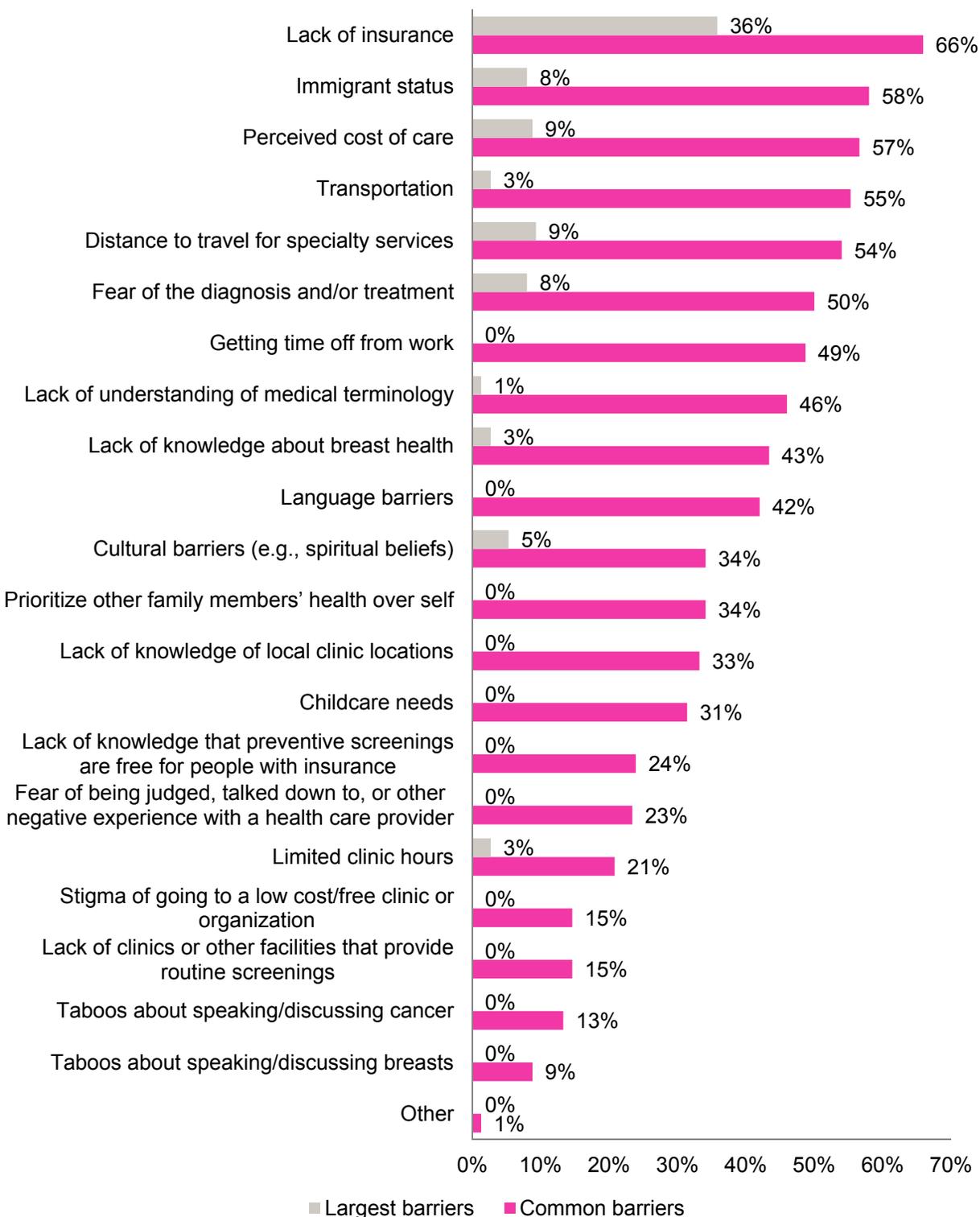


Figure 4.6. Barriers to receiving treatment within rural northeast Colorado

Provider organizations serving rural northeast populations were less likely than providers in some of the other regions to provide education about breast health/health care generally. It was also less common for patient navigators in this region to be required to go through training. Patients in the rural northeast had to travel further on average than patients in some of the other regions to get diagnostic services and treatment. Providers in this region reported the greatest increase in underinsured patients, relative to the other regions, and higher percentages of foreign-born patients.

The interview findings for this region echoed the concerns raised in the Quantitative Data Report and expanded on the survey findings. The picture of this region drawn by the interviewees is one of widely dispersed farmers and ranchers, whose greatest health care challenge is the tradeoff between distance and availability of services, especially specialty services. For many, their nearest town may have a clinic that provides basic preventive care (e.g., clinical breast exams), but not screening mammography, diagnostics, or treatment. Even those living in one of the larger towns in this area may have specialty services available only one day a week, and must travel farther for treatment – radiation in particular, and for those who are uninsured or underinsured and need charity care, often the travel required is even farther to reach a facility that provides charity care.

Barriers associated with the need to travel for services were mentioned by nearly every interviewee from this region. The implications of this barrier vary depending on the person's specific situation, but range from the cost of gas (and other travel costs) or the cost of a ride, to the difficulties of getting a ride (for older people who don't drive, or those fatigued by treatment) for either one-time or recurring appointments, to discomfort driving in the city (for those traveling to Greeley, Fort Collins, or Denver for services), to the difficulty in getting time off work and/or losing wages.

- "It takes people away from a job. It can take half a day out for radiation. So another factor is losing their income when trying to get treatment. It is a burden even if you have insurance. Most people have a high deductible to keep their monthly payment low."
- "There's a service - it's called County Express – it's a bus system that can pick [people] up and take them to their treatment. If they have Medicaid, it pays for it, but if not it's extremely expensive - \$75 each way."

Suggested solutions for this barrier included finding ways to increase the availability of specialists. The mobile mammography van works along these lines, and was mentioned as a valued resource by everyone in communities without mammography available; however, there remained challenges with where follow-up care was available for those with an abnormal result, as often diagnostics and treatment requires substantial travel. Another suggested solution was to increase funding to defray travel costs, including gas, hotels, and meals. Others suggested social media solutions to help people coordinate carpools as well as share experiences about how the travel needs impacts treatment experiences.

In addition to the barriers created by the lack of availability for services, the interviewees described common psychological barriers for their communities. Interestingly, a predisposition against preventive care was mentioned as a barrier both for the older farmer/rancher residents of this region, and for the newer immigrant residents.

- “Their community out there (farmers) is not real focused on preventive care because they’re too busy and they don’t have time. Preventive care ... we’ve got a lot of different cultures, we’ve got a lot of Hispanic/Latina ... a lot of people don’t have the education to go get care until they’re very sick.”
- "People from the ranching community tend to NOT to go to the doctor – tough people mentality – most have private insurance or Medicaid but don’t seek care unless something is really wrong."
- "In Morgan we have a fairly large refugee population (majority are Somali) and for them prevention is a new concept. In their culture, they don’t go to the doctor unless you are sick."

Interviewees also noted a culture of “not wanting to know” that they believe stems from both a fear of the costs patients will incur if there is something wrong with them, and also from a fear that a diagnosis is a death sentence. Many interviewees noted the need for education campaigns letting people know there are resources to help with costs, and also educating about how treatable the disease is especially if caught early.

The issue of cost as a barrier was also widely noted. Out-of-pocket costs, particularly for diagnostics and treatment, for those who are uninsured or insured with high-deductible plans are a barrier. The uninsurable (primarily undocumented individuals) may need to travel farther to receive care, which compounds the barriers of cost and lost time from work. For those who are insured with a high deductible, many find they cannot afford the out-of-pocket costs, yet do not qualify for any financial assistance unless they quit working altogether. In this region, several providers described teachers or nurses in this situation, compared with the Mountain and Resort region where the underinsured are often lower-level service workers. This exemplifies the different costs of living between the rural northeast and the Mountain and Resort regions.

In general, it was noted that insurance coverage is not well understood by either patients or doctors. Several interviewees mentioned that it is not uncommon for them to have patients from this region who do not want to get insurance, saying, “I’ll take the penalty.” Others have insurance but either do not know that it covers preventive care, or assume that it covers everything and are surprised by bills for diagnostic care. Compounding this problem is a “lack of understanding of what to get/when.” Several interviewees noted that there is confusion about who should be screened and when, partly due to the different recommendations coming from different groups. One noted that providers also need help keeping up-to-date on recent research and the latest trends and would welcome educational materials from the Affiliate.

The suggested solutions for the cost barriers focused on needing funding to pay for care and encouraged some adjustments to how Affiliate funding is allocated. Said one interviewee, “With the Affiliate, we get that chunk of money and we want to cover like 20 people, but one or two people could wipe out our entire grant [if they end up needing treatment]. So our grant admin has said we only pay \$3,000 per person so we can serve 20. I have a hard time ethically saying, ‘I’ll get her screening covered, but she’s going to need radiation and chemo and I’m not going to get it done because I can’t pay for it.’ So if we’re going to [pay for] people’s [care using] Komen Colorado [grants], I think it needs to be all or nothing and that includes even the genetic testing.”

As further feedback for the Affiliate, many interviewees noted the burden of grant reporting. Several added that they either had stopped or planned to stop applying for Affiliate grants because they did not have the administrative resources to handle the grant reporting.

- "The detail of reporting with the Affiliate is very cumbersome. I know that's been a discussion we're currently having with management. They're not sure they can even support someone applying for or administering the grant next year because of how cumbersome it is. As a nurse I can't do it. The implications are huge for our community because it really has benefited our patients and what are we going to try to do to support those patients if we don't have [funds from] the Affiliate?"
- "Even this grant report – it should take you a couple of hours to put together, but it will take a couple of hours to put together and two or three times that to get it into the system and it doesn't feel respectful of our time. I don't think they appreciate how many hours it takes."

Mountain and Resort Towns

Similar in some ways to the rural northeast, the Quantitative Data Report pointed to the rural nature of Mountain and Resort towns and limited access to care as a primary concern. Additionally, in this area the terrain and weather conditions can exacerbate transportation and access challenges. The tourism economy dominating this region results in a high cost of living and a high degree of income inequality, adding additional financial challenges for those working in the service industry. The service workers in this area are also more likely to be foreign-born and linguistically isolated.

Similar to findings from the rural northeast region, the survey findings suggested that knowledge is a barrier at the initial entrance to the health care system (Figure 4.7). Perceived cost of care is also a fairly common barrier at multiple stages. The top five most common barriers to receiving preventive care were lack of knowledge about breast health, fear of the diagnosis and/or treatment, perceived cost of care, lack of knowledge that screenings are free for people with insurance, and lack of insurance. The largest barrier was lack of insurance.

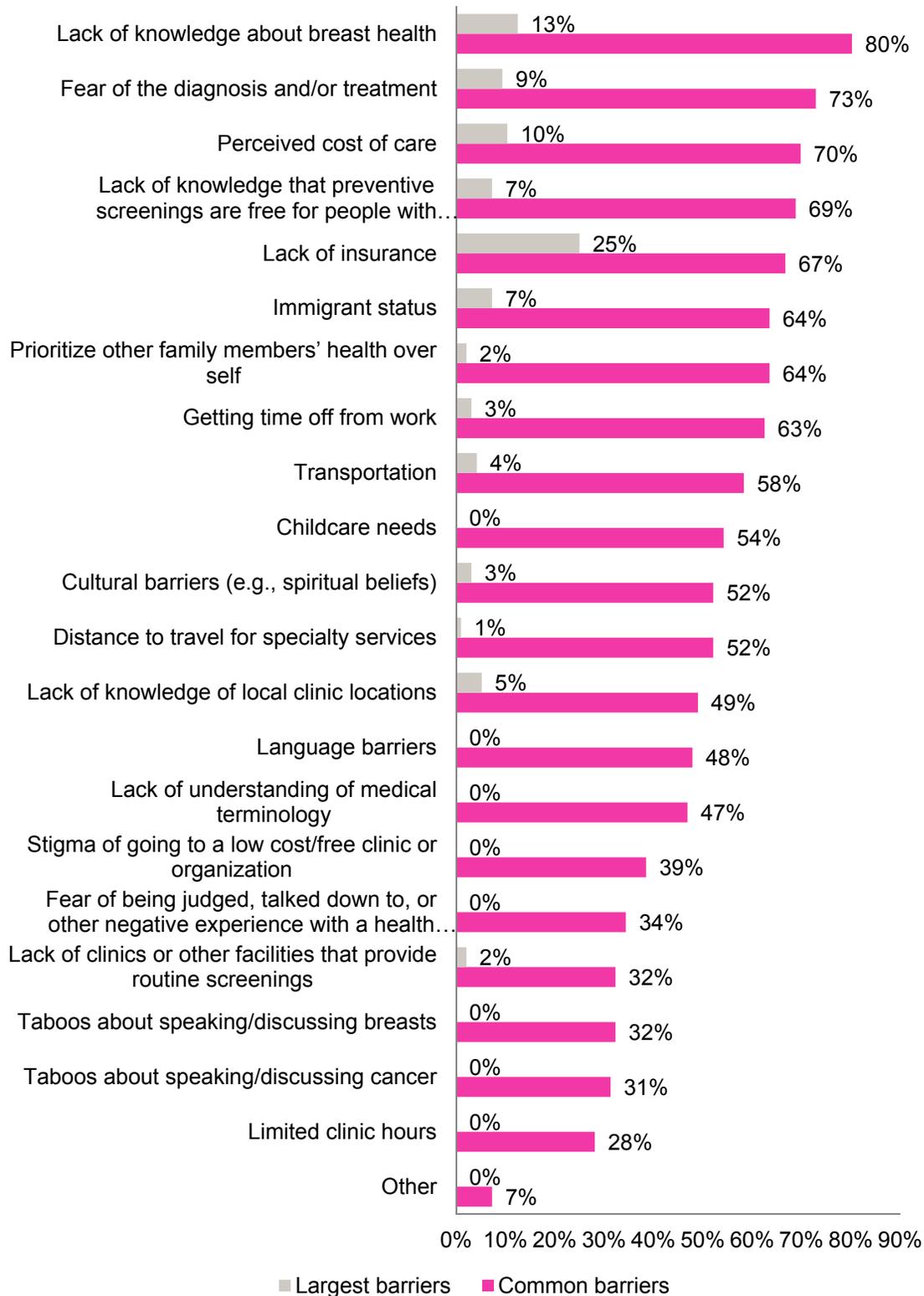


Figure 4.7. Barriers to receiving screening within mountain and resort towns

The top five most common barriers to receiving diagnostic testing were lack of insurance, fear of the diagnosis and/or treatment, perceived cost of care, transportation, and getting time off from work (Figure 4.8). The largest barrier was perceived cost of care.

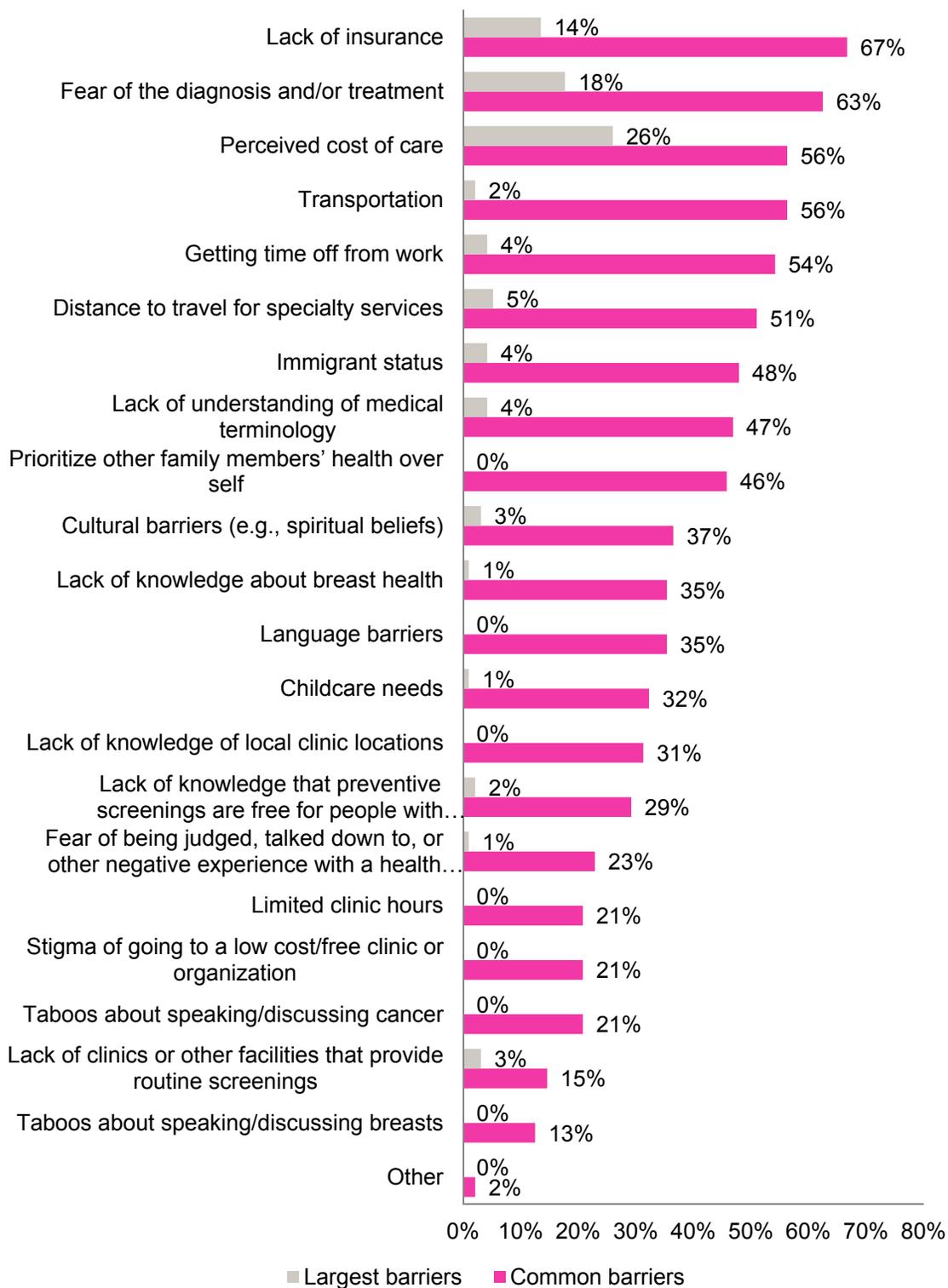


Figure 4.8. Barriers to receiving diagnostic services within mountain and resort towns

The top five most common barriers to receiving treatment were lack of insurance, transportation, distance to travel for specialty services, perceived cost of care, and getting time off from work (Figure 4.9). The largest barrier was lack of insurance.

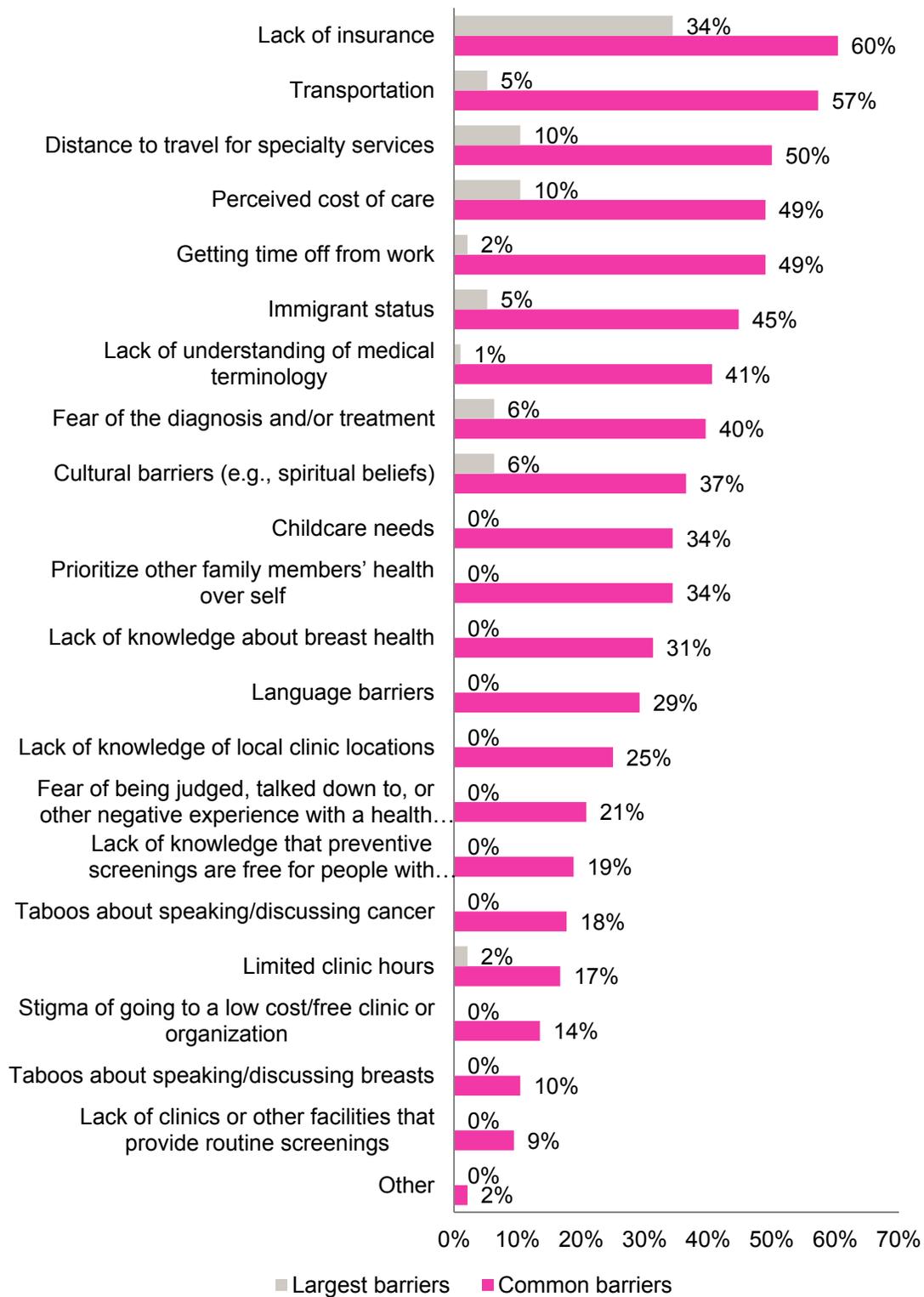


Figure 4.9. Barriers to receiving treatment services within mountain and resort towns

Provider organizations serving larger mountain and resort populations were the least likely to provide education about breast health/health care generally. More of these organizations included transportation to and from a hospital or clinic in their patient support services. Similar to the rural northeast region, fewer organizations reported that their patient navigators were required to attend training.

Providers reported that a higher percentage of their mammogram patients in the past 12 months needed follow-up diagnostic services. Similar to patients in the rural northeast, patients in this region had to travel further on average than patients from other target communities to get diagnostic services and treatment. Providers also reported higher percentages of foreign-born patients in this region. Providers in this region were more likely than other regions to have a full-time translator for their non-English-speaking patients.

Interviews with mountain and resort providers underscore the issues stemming from income inequality in the area and describe a situation in which the already limited availability of providers is exacerbated for those with Medicaid or without insurance. The high cost of living in the area has also created a situation where those who are very low-income for the region are not considered low-income with respect to the federal poverty thresholds, so they do not qualify for Medicaid, private insurance tax credits or other insurance subsidies, yet they often cannot afford the monthly payments for even a high-deductible insurance plan, let alone the out-of-pocket costs associated with such a plan. Fear of costs was mentioned as a barrier to seeking or following-up with care by nearly all the interviewees in this region. The greatest needs in this region are affordable services for these populations, and financial support across the continuum of care for those who are underinsured.

- “Incomes are high here comparatively, so people might not qualify for subsidies in the exchange, but are barely making it here.”
- “I have been on the phone updating my own internal referrals and so many of our providers in the Roaring Fork Valley are not accepting new Medicaid patients. If a woman needs to see a breast surgeon or have a surgical consult, providers aren’t seeing Medicaid.”
- “A lot of it is the cost. If they don’t have insurance that covers treatment plans or medication, a lot just won’t go through with it.”

Further, a majority of the uninsured in this region are undocumented workers in the service industry. Several providers described challenges with arranging screenings for these individuals, including different eligibility requirements for services at different facilities. Providers described both the structural barriers facing these patients and also personal barriers for a group that is reluctant to fill out forms and nervous about seeking treatment because of fears of deportation. Providers expressed wishes for better collaboration across the system of care to help reduce barriers for these patients as well as others who are underinsured.

- “There are not enough providers in the area for annual exams for [undocumented patients]. For Carbondale, Aspen, Glenwood, there are 20,000 people and four places where they can go to get access to a provider. It’s not enough.”
- “As soon as someone asks for income verification, right away it’s, ‘whose name is on it...what SSN’. If we say we would like [for Affiliate funding] to help undocumented patients, then we need a willingness [for providers] to accept self-verification of income.”

- “Immigration status [is a barrier] too – they have that fear that they are going to get in trouble.”

In contrast to the rural northeast region, none of the providers interviewed in the mountain and resort region noted any barriers due to a reluctance to seek preventive care. In somewhat the opposite direction, mountain and resort providers were more worried about the system not having the capacity to meet the needs of those seeking care. Several expressed a reluctance to do any additional outreach because they did not have the resources to support any more patients.

- “We need community education about the resources that are available. We don’t have a lot of resources for media campaigns or outreach. But the flip side would be that we get them here and then don’t have the dollars to take care of everybody. All our programs are limited by the grant funds.”
- From a provider who had stopped doing outreach: “Women who’ve never been screened, we want to get them, but we are already using the funds we have with our established patients.”

Similar to the rural northeast region, however, several providers mentioned confusion around when to start breast screenings and how often to screen.

Barriers stemming from the lack of available care and the distance needed to travel to receive care were also common in this region, particularly for people living in more rural areas or smaller towns. Similar to the rural northeast, the distance challenge is compounded for low-income people who may have more difficulty getting time off work and may be less likely to have an available vehicle that is capable of the mountain travel needed to access care.

- “[Patients] need to drive over a mountain pass in any direction for hospital services and mammography services. If you’re a woman living in our county it’s going to be an entire day to get treatment. It’s at least a 100-mile trip one way. At this point, if you live in Park, you’re going to have to make an appointment in Summit, Chaffee or Jefferson County just to get a clinical breast exam.”
- “We do have a mobile mammogram van. But any kind of follow-up work has to be done in Denver. Need transportation.”
- “Even if it’s just navigating our valley, [we have transportation issues]. With Medicaid expansion, there are limited Medicaid providers here, so if a woman has to go to Grand Junction or Denver that’s a huge barrier. For people who need treatment, there are no treatment providers locally for anyone. So if you have a family with no vehicle or a vehicle that can’t get over the pass to Grand Junction ...”

The support desired from the Affiliate by providers in this region is consistent with the unique financial situation in this region, and the needs of sparsely populated areas. Several requested higher income thresholds for qualifying for financial support to accommodate the higher cost of living in this area. Many said more dollars were needed for treatment. Others pointed to the need for transportation support.

- “[The Affiliate’s] income guidelines are too strict. I think it needs to be increased to the 300 percent [FPL] income level.”

- “We need funds for screenings for people not eligible for Medicaid or tax credits, but who can’t pay premiums.”
- “It’s always been a challenge with our patients [covered by the Affiliate] – they reach a point, with that positive diagnosis - and there are no treatment dollars and it’s like, ‘well we’re done, we’ve got you this far,’ and there’s no [Komen Affiliate grant to pay for] treatment. If we could bring treatment dollars to the Roaring Fork Valley that would be wonderful.”
- “Last year to have the [Affiliate] funding, we had to guess. We don’t have enough volume to where we can confidently say we’re going to serve 20 this year, or 20 are going to need help. If I knew I was going to have four women needing treatment support this year I would have asked for that. One of those things unique to a small community is we don’t have the volume so it’s difficult to predict. So if I wasn’t locked into using the money – could be flexible to use the money where needed in small areas like ours.”
- “We get a ton of calls for treatment patients, and they’re in treatment for six weeks every day of the week. So they need a shuttle and money. Typically they lack transportation altogether.”
- “I would like to do more outreach and education and the one resource I’m lacking is the time and creative ability to develop something that would be impactful in the community. Along with Affiliate facilitating medical professionals who could assist [as guest speakers at educational events], even sharing best practices, or models of outreach and education that work in other communities would be helpful. I feel like I’m reinventing the wheel.”

One provider summed up an ideal vision for the mountain and resort towns:

- “I think it would be having access to top providers in all communities in rural areas. There would be great clinics in all communities with doctors that accept Medicaid. And transportation that would be done for free to appointments down in Denver. Ideally it would be great to have treatment in the mountains.”

Medically Underserved Communities within Front Range Counties

As the Quantitative Data Report noted, the Front Range counties are the most populous and are home to the largest raw numbers of people needing screening, care, and support. Late-stage diagnosis is a particular concern in this region, particularly for underserved sub-populations including those with lower educational attainment, low-income, foreign-born, linguistically isolated, rural residents and underinsured.

The survey findings suggested that although knowledge again is an issue, other aspects of life, such as work and caring for other family members, can also be barriers. The top five most common barriers to receiving preventive care are lack of knowledge about breast health, fear of the diagnosis and/or treatment, immigrant status, lack of knowledge that screenings are free for people with insurance, and prioritizing other family members’ health over self (Figure 4.10). The largest barrier was lack of insurance, but there was not necessarily a lot of agreement.

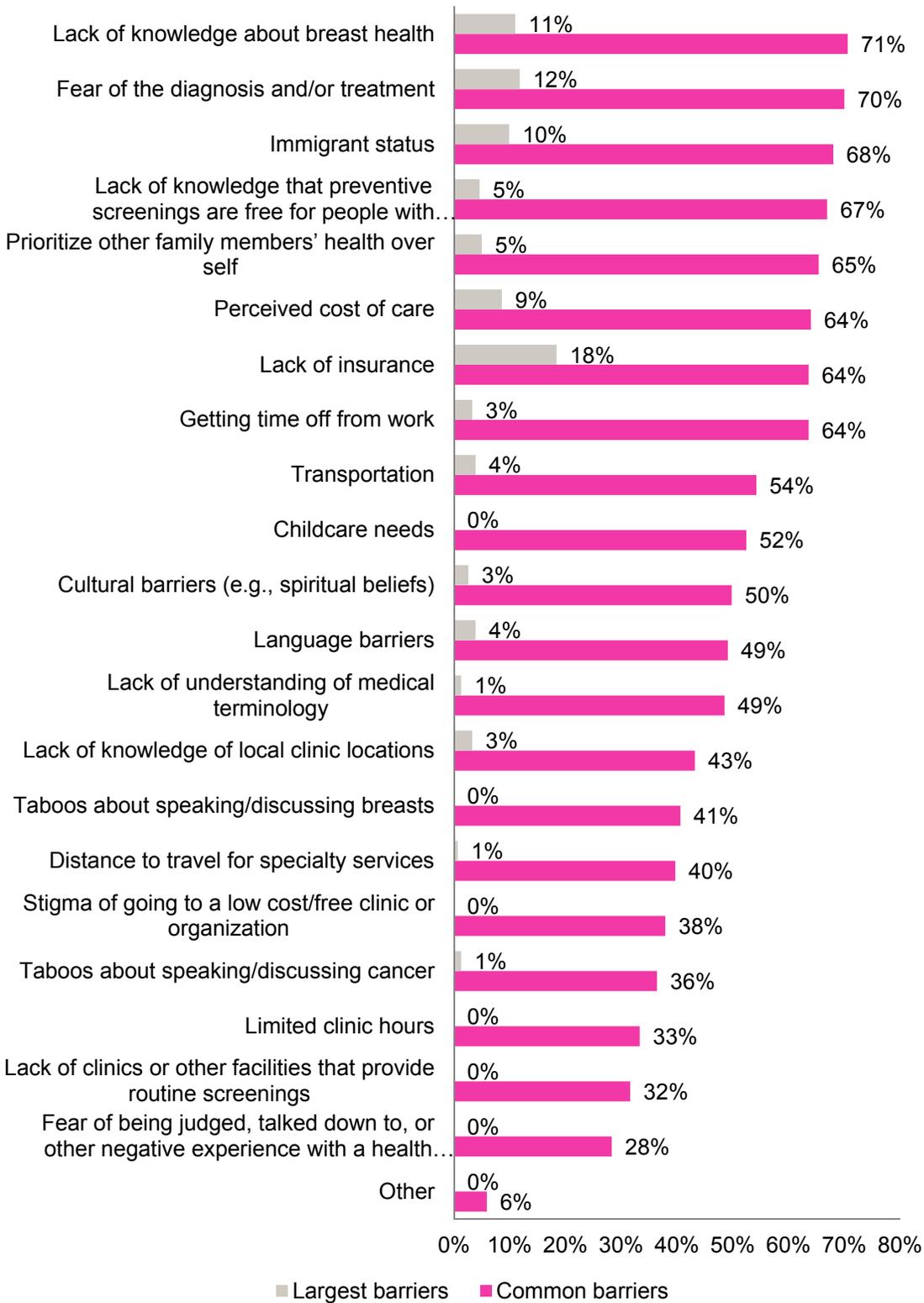


Figure 4.10. Barriers to receiving screening services within the Front Range

The top five most common barriers to receiving diagnostic testing were lack of insurance, perceived cost of care, fear of the diagnosis and/or treatment, getting time off work, and transportation (Figure 4.11). The largest barrier was perceived cost of care.

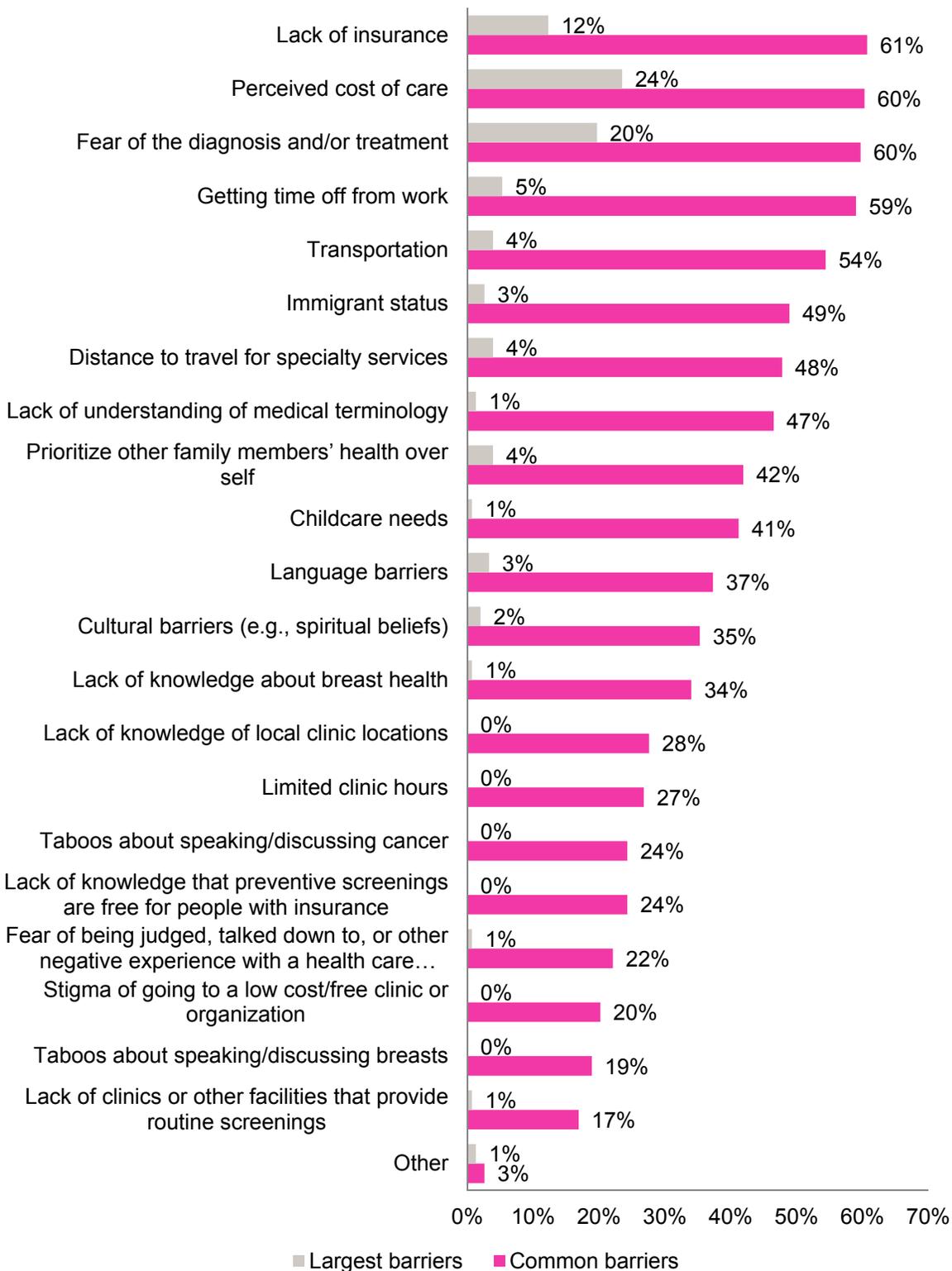


Figure 4.11. Barriers to receiving diagnostic services within the Front Range

The top five most common barriers to receiving treatment were lack of insurance, perceived cost of care, transportation, getting time off from work, and immigrant status (Figure 4.12). The largest barrier was lack of insurance.

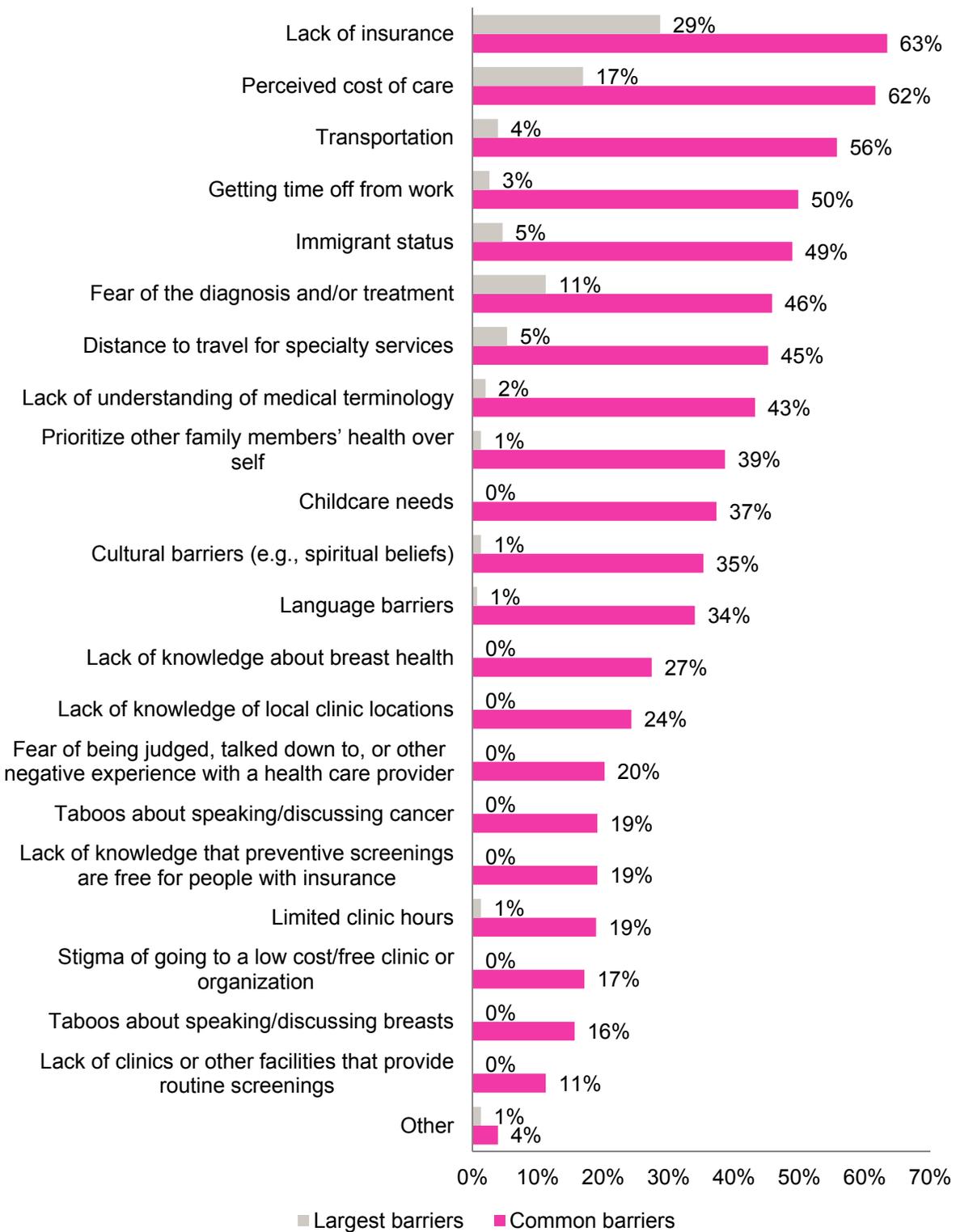


Figure 4.12. Barriers to receiving treatment services within the Front Range

Not surprisingly, providers in this region offer a lot of services. They were the most likely to offer diagnostic services, and patients in this region traveled shorter distances for follow-up care. Providers in this region reported more racial and ethnical diversity among patients, as well as more LGBTQ patients compared to other regions. Patient navigators in this region were more likely to have completed training.

Interviews with Front Range providers covered a system of care that is both more comprehensive and more complex than that available in either the rural northeast or mountain and resort regions. However, the greater number of resources available in urban areas does not mean those resources are sufficient to meet the need, particularly for the un- and underinsured. These interviews provide glimpses into a few communities along the Front Range and the barriers they face. In the bigger picture, these interviews also showcase a complex system of resources that are not well-understood by everyone in the provider community, let alone patients seeking care.

Similar to other regions, low-income individuals face a number of interrelated barriers. Many fear the costs of care, and may refuse treatment (or fail to seek care) because they assume they cannot afford it. Explained one provider, “For the folks we serve, it’s deciding whether or not to seek treatment or diagnosis vs. paying the rent. People are literally making those types of decisions, whether they can afford to do one or the other. [That’s] probably the biggest barrier.” Many patients (and providers) are not aware of the financial resources that may be available to them, and others may feel there is a stigma associated with accepting assistance.

- “Women who get a screening mammogram, even insured women, who get called back for a diagnostic mammogram or ultrasound will refuse it because it will be out of pocket. Patients that are uninsured that go onto Affiliate or WWC vouchering are in a better place than insured patients who will pay \$800 to \$1000.”
- “[Some with insurance] don’t come to follow up because they can’t meet deductible and are over income for WWC and Affiliate. They’re not low enough income, but still don’t have \$5000 lying around to pay their deductible.”
- “Some can’t even afford the \$20 copay at a clinic. [There’s a] fear of not knowing what the cost will be, that it will be like a surprise cost is a problem. That there will be something else that they will be charged for. That’s not the kind of thing that they can afford to have happen.”
- “I know there are a lot of services that provide help for women without insurance. Most people know it exists, but don’t know where.”

In addition, low-income, and particularly undocumented, workers have little ability to negotiate time off work for an appointment, and may lose wages for any time that is taken. Transportation challenges exist in the Front Range too. Public transportation is more widely available, but often requires more time and making multiple connections.

- “Especially for lower income patients, they have one day off to get medical care and it’s the only day they can do anything or they might lose their job. They have less flexibility in time to take off for care – how much, when.”
- “People who have to come in for radiation for a whole week or for chemo...most employers just don’t have the ability to accommodate that when you are lower income. When people are unable to work, they don’t have PTO so income is reduced or they lose

their job...so no money for food, for gas to go to treatment, for clothes. It's just a horrible cycle that people get trapped in that can feel overwhelming.”

Navigating the Front Range health care system becomes more complicated depending on insurance status. Many providers for the insured are linked to a particular insurance network, and other providers may accept only Medicaid/Medicare, or only uninsured patients. Some providers may accept only a limited number of Medicaid patients. Many provide only a particular step in the continuum of care. For patients who are unfamiliar with the health care system, the need to visit a series of different clinics with a series of different qualification protocols can be overwhelming. In all regions, a need for patient navigation was expressed, but it was particularly emphasized by Front Range providers. In all regions, it is common for patients to visit one clinic for an annual exam and clinical breast exam, another clinic for a mammogram, a third if diagnostics are needed, and sometimes a fourth if particular treatments are needed. Providers describe every handoff in this chain as a potential place for women to drop out of the system.

- “You’ll have patients with symptoms for years but don’t address it because they don’t have the ability or resources to navigate through the system.”
- “They don’t know how to navigate the system. They say, ‘I have insurance, but never went to the doctor because I don’t know how to use it.’”
- “If patients have to schedule their own mammograms, there is the possibility that they will not do that.”
- “If a woman came here – say, Ethiopian or Sudanese or some kind of other language speaker – we would have to support her when she went to get her biopsy and if we did not do that she would not show up for her biopsy date.”
- “[It is] difficult to find specialist providers to take a Medicaid client [where the specialist] is not 100s of miles away.”
- “There is a barrier for low-income or Medicaid covered folks about how to schedule (due to lack of knowledge of where to go and lack of enough providers).”

One factor described as complicating the handoff challenges is the limited number of treatment dollars.

- “Some of our agencies like to depend on the mobile van coming up through St. Joes to meet screening needs so they can reserve more [of their funding resources] for diagnostic and biopsies. But then patients have to go to Denver for diagnostic work up. That’s a disservice to those patients. We should have enough dollars in a community to have all of their [patients’] care as close as possible.”
- “Where we often see a gap at our clinic is we’ll run out of treatment dollars even earlier than diagnostic and screening money. Then a lot of women will have to choose to go to other places where there still are funds. And if there weren’t those other places, they would delay [treatment] even further.”
- “A barrier treatment-wise for Banner/McKee, is they have a limit for their treatment funding dollars. They only pay \$3,000. What is \$3,000 going to do for treatment?”
- “For the Latina population, undocumented ... we can only serve them up to the point of biopsy and then our care stops. We don’t know where their treatment should begin. [The location that used to receive Komen grant funds to pay for treatment costs] does not have dollars for treatment this year. So that has been a major concern. County hospitals are limited [by Colorado Indigent Care Program] ZIP codes of who they can treat –

county residents have to stay within their county. We've been sending people to [Caritas Clinic – in Denver].”

- “Anything that the Affiliate can do to help people receive their treatment locally when treatment facilities exist locally so people don't have to drive to a different community.”

In addition to structural barriers, some providers pointed to cognitive barriers, such as fear and misinformation, preventing patients from seeking care. A few providers had encountered the misconception that a person was not at risk because they had no family history of breast cancer. Many also pointed to confusion about the screening guidelines and when they need to start and how often they need to be screened. Two providers noted that Boulder patients often refuse mammograms because of fears of radiation. Others saw fears of diagnosis, either because they believed it would be a death sentence, or because they had witnessed a friend or family member suffer through treatment. These reasons were often pointed to as causes of late-stage diagnosis.

- “A lot of people think if they don't have a family history they can't get breast cancer. We always tell them that's not the main risk factor for breast cancer.”
- “It is still not clear what they should have done, in terms of what age to start screening and how frequently.”
- “I really think it is fear of the diagnosis. Fear of chemo and radiation. Fear that they watched a loved one suffer from some type of cancer and the perceived horrendous treatment that they went through.”

In the Front Range, many of the underserved are foreign-born, including refugee populations from various countries, as well as immigrants, both documented and undocumented. Barriers for these groups are compounded for those who speak little to no English, and especially for those who speak a language other than English or Spanish. More important than the language barrier though, are a number of “cultural barriers” including an unfamiliarity with the concept of preventive care, and certain taboos about the breasts. These “cultural barriers” were the most often noted reasons for women not seeking care, even when a breast health concern was present, and increasing the probability of late-stage diagnosis.

- “When they come to the US and interpreters are telling them to get a mammogram, it is difficult to translate to them when they haven't been around that the majority of their lives. The same thing for diagnostic and treatment. There are different views about what cancer is in different cultures.”
- “Breast is taboo...can't talk about it or touch it. The first message we give is that it is okay and you need to do it and it is part of your body. You need to talk about this with your family, at dinner time. So it is not secret.”
- “‘I don't feel any pain right now’ [so they don't think they need to go for follow-ups]. That is the thing that is the difficult part here. They're from a world where you don't do [preventive] work. To many people [the preventive work is] not that important.”

Several of the providers interviewed suggested that the place to start with these populations was outreach and education in their own language, if possible through trusted community organizations to explain the need for screening and how to get it. One recommended providing “information out in the community that is in Spanish and they call a number with a Spanish speaker to schedule an appointment, and then they see a Spanish speaking provider. Through

word of mouth, the rest of the community will be influenced to engage in care. Just having a system that is a bilingual experience all along the continuum.”

- “If you’re new into society and you don’t know English and someone calls you and can explain to you why this is important then they start trusting you and they call you back. Right now there is no such system. The Affiliate could be that resource.”
- “Could the Affiliate come up with a guide of the most culturally responsive providers or how to access those providers for your clients?”

For all non-English speakers, providers stressed the need for culturally-competent care in their native language. As one provider explained, “Providers give the same level of care [to both English-speaking and non-English speaking patients], but attention to personalizing for patients is not the same. Using language services results in a minimalist approach. They [providers] would take more time with an English speaker. It is a barrier to care. I don’t think the emotional needs [of non-English speakers] are being met, not as personalized.” A few interviewees suggested that the Affiliate could help providers develop language or cultural competence skills. “It would be really beneficial for the Affiliate to offer grantee training around cultural competence. Like what they offered for LGBT patients. Training about what language [wording] to use when asking questions.” Another suggested that even producing a Spanish-language DVD explaining breast health care that could be played in waiting rooms would be helpful.

Others suggested more structural supports. Several noted childcare challenges, particularly for Hispanic/Latina patients. One recommended, “Having waiting rooms where kids can be entertained while services go on. ... not all imaging facilities we work with have bilingual staff or a children’s area in the waiting room.”

Across the Front Range, many providers touted the benefits of the mobile mammography van for serving both foreign-born and other low-income populations. Though, as noted above, being screened by the “mammo van” can have implications for where follow up diagnosis and treatment services must be obtained.

- “Just going across town can prevent someone from getting a mammogram. We need a mammo van that is readily available.”
- “I love the mammo van. It really overcame the transportation issue. Many moms don’t have transportation so we are putting the van in the places closest to them. We have good relations with churches (both Christian and Catholic). We talk to them, do recruitment and education there. Then we send the van to those locations. Really easy. It can be churches, schools, rec centers. Any places in the community that people recognize.”
- “Everyone wants a mammogram, but they don’t want to go to the hospital for fear of being exposed if undocumented. One concrete thing we could tell you that works is a mammography van. It removes more than one barrier all at once. It allows people to come together as a family. It removes cost. It’s safer – no clinic, no hospital.”
- “If [Affiliate] were to make services more convenient to their lives (like come to them, offer travel assistance, language assistance), it would help. Helping fund mammogram vans [for example].”

When asked what the Affiliate could do to help remove barriers, Front Range providers offered a variety of suggestions. Many recommended education and outreach activities that ranged from explaining insurance, explaining screening guidelines, and explaining what resources are available and where in each community. Several however, indicated that despite the needs for education and outreach, if forced to choose, they would first put funding toward screening, diagnostics and treatment. Similarly, a few described needs for funding for transportation or other support services, but others said those should not trump direct services.

- “Honestly, our Affiliate funds go so quickly towards the cost of screening and diagnostics, I would rather see money continue in that direction instead of paying for someone’s gas.”
- “I recall seeing the percent of money going to screening vs. survivorship issues, and there’s not as much funding going in that direction [survivorship]. I think it’s equally important to deal with these patients as they start and finish treatment. I’m not saying survivorship issues are more important, but equally important as treatment.”
- “You can put a bunch of money to outreach and community health workers, but if you don’t have money for services, then that outreach is kind of...it’s not a complete balance. One is needed a lot more. Word is out there that screening is important. That’s not the tricky part. But the insurance part is.”
- “We very much need funding for diagnostic work up. The Affiliate has always focused on serving a population at 250 percent of FPL but with ACA and Medicaid expansion, I think they should consider expanding the FPL limits/considerations on the grants. 250 percent FPL is still a low income if you need a breast biopsy. A lot of women who are considered too high income still need a lot of help. That to me has always been hard—that there is an income limit at all. With limited funding, you do have to start someplace. But some patients with very high need are just slightly out of the need range. If someone feels it is too expensive and then won’t go through it.”

In addition to funding needs, many suggested policy efforts that they would like to see Affiliate work towards. For example:

- “... getting large companies to agree that they should have wellness days, encourage health care, promote those things, like one day in October – allow people to go do certain things for men (e.g. cholesterol screening), women, whatever. Health care days with labs may be something we think about to allow people time and space to do certain things where they can get everything done at once.”
- “In Colorado, so many women are not part of the [Medicaid] BCCP program. All these women who still need to be served. When people have brought that up to the state department to expand BCCP to include undocumented women, they shy away from it. It would be great to have the Affiliate delve into that political system. And the Affiliate has done excellent work lobbying for different policies like lobbying for women who weren’t enrolled via WWC into BCCP. They already have a great history of successfully lobbying for important policy changes.”
- “One thing, one policy that is a huge issue is someone must have legal residency for five years to qualify for Medicaid. So reducing the number of years required to qualify for Medicaid is something the Affiliate could push for.”
- “The Affiliate could work at a legislative level to get insurance companies to remove the deductible coinsurance component of diagnostic mammography. For patients with

Affiliate or WWC, they're not in that boat because they get the right test ordered for them. In some ways they are in a better place than privately insured patients."

Qualitative Data Findings

Limitations of the Data

The qualitative data in the present report were collected from providers of health care services and support. While these individuals are able to speak on behalf of a great number of patients/clients they come into contact with, and can report on the patterns that they see based on their experiences, they may have relatively less insight into barriers faced by those potential patients/clients who do not present themselves for screening, diagnostics, or treatment. Further, these data do not provide direct input from patients themselves, who would have a somewhat different perspective from the nurses, navigators, and other service providers represented herein.

Implications and Recommendations

The qualitative research highlighted some recurring concerns and areas of focus for the Affiliate going forward. Areas for further exploration include:

- Qualitative data from breast cancer patients and individuals who have not received a mammogram within the last two years (or ever) for a mid-cycle update to this Community Profile. Resource constraints prohibited the Affiliate from gathering qualitative data from those populations.
- Providers' understanding of Affiliate funding guidelines and a need for additional communication with providers about funding guidelines and resources.
- How the Affiliate's funding guidelines align with the needs of the underinsured, particularly those who are not Medicaid-eligible, yet struggle to afford the monthly payments, coinsurance, and deductibles of private insurance plans.
- Providers' understanding of cultural competencies needed for serving Hispanic/Latina patients and other foreign-born populations.

In addition, the following recurring community needs were identified as areas for the Affiliate to intervene:

- Communicate with individuals directly about what financial resources are available to them and where in their communities they can go to access those resources. However, many providers struggled with the tradeoffs of putting the Affiliate's resources toward education and outreach versus patient care (i.e., screening, diagnostics and treatment), and most concluded that if limited resources were available patient care would trump outreach.
- Partner more closely with staff from Women's Wellness Connection (WWC), Medicaid Breast and Cervical Cancer Treatment Program (Medicaid BCCP), and county health departments where BCCP enrollment applications are processed, to train non-WWC providers about the updated Medicaid BCCP eligibility.
- Help reduce confusion among providers and patients about which breast cancer screening guidelines to follow and why.
- Continued support for undocumented individuals who have few resources other than the Affiliate for breast cancer screening and care.
- Assist rural and remote areas with service availability and transportation challenges. More mobile resources to bring care to individuals could be beneficial as well as more transportation resources to bring individuals to care.

Findings specific to each target community are discussed below.

Hispanic/Latina Women

Overall, the Hispanic/Latina population faces many concerns based on the region in which they live. However, there are some unique issues for this population across regions—specifically, immigrant status and language/cultural barriers. The Quantitative Data Report found that Hispanic/Latina women in Colorado have lower screening percentages, and an increasing trend in late-stage diagnosis compared to the population as a whole. The survey findings suggested that immigrant status is a large barrier at all stages of the breast cancer continuum of care.

Immigrant status prevents some from seeking out care because this population fears being turned over to federal immigration officials. They are also ineligible for most types of financial assistance. Additionally, while many providers have some form of Spanish-language services, there is still a need for more culturally sensitive care.

Rural Northeast Colorado (Colorado Health Statistics Region 1)

Availability of services and transportation to those services are some of the biggest concerns for the population in the rural northeast. Traveling greater distances for services can be a barrier for various reasons. There are costs, such as lost wages and time, but there are also difficulties associated with fatigue after treatment and discomfort with cities preventing people from driving.

The Quantitative Data Report described the population in this area as older, poorer, and less likely to be insured than in other areas. The survey findings suggested that lack of knowledge about the need for preventive care was a barrier in this region, especially an early stage barrier that prevented screening. There appeared to be quite a bit of confusion surrounding what is covered by insurance and which screening guidelines to follow.

Mountain and Resort Towns

Providers that serve mountain and resort populations identified many of the difficulties that were common in for rural northeast communities, such as access to care and transportation. Additionally, this region faces a large income inequality, a high cost of living, and a large undocumented worker population that works in the service industry.

In this region it is difficult to find providers that are accepting Medicaid and low-income patients. Additionally, with the high cost of living, patients who cannot afford health insurance also do not qualify for subsidies because they make too much money. The large undocumented worker population tends to both be a low-income group and one without insurance.

Medically Underserved Communities within Front Range Counties

Although there are many resources available in Front Range counties, these resources are not meeting all the needs of un- and underinsured patients. Low-income patients are unable to get time off work to seek breast health services, nor do they have the financial resources to cover services not covered by insurance. Additionally, there are still misconceptions among patients regarding who is at risk for breast cancer and which screening guidelines to follow.

Those who do enter into the breast cancer continuum of care find a very complicated system in the Front Range. Especially for patients with little knowledge of the health care system, navigating can be a large barrier to receiving care. Immigrant populations in the Front Range

region often do not understand the US health care system and may have any number of cultural barriers preventing them from seeking care.

Mission Action Plan

Breast Health and Breast Cancer Findings of the Target Communities

Because Susan G. Komen Colorado's service area covers 72 percent of the state's population, improvements in breast health outcomes within the Affiliate's service area will substantively affect the state's overall ability to meet breast health targets established by Healthy People 2020 (HP2020). Komen Colorado's examination of breast cancer data, demographic projections, and socioeconomic indicators that have been tied to adverse breast health outcomes, have led the Affiliate to prioritize the following four target communities in its grantmaking, public policy, public education and outreach, and other programming efforts for the next four years:

- Medically Underserved Communities within Front Range counties
- Rural Northeast Colorado (Colorado Health Statistics Region 1)
- Mountain and Resort Towns
- Hispanic/Latina Women

Key Findings: Medically Underserved Women in Front Range Counties

Adams, Arapahoe, Broomfield, Denver, Douglas, Larimer and Weld Counties will be home to 70.1 percent of women aged 40-64 within the Affiliate service area by 2020. None of the first six counties are projected to meet the target for late-stage diagnoses of breast cancer established by HP2020, and Weld is not expected to meet the HP2020 target for the breast cancer death rate.

Moreover, the late-stage diagnosis rate for Black/African-American women in Komen Colorado's service area is increasing at a rate of 8.9 percent annually - compared to an annual increase of 2.0 percent for the service area. Among Asian/Pacific Islanders, the late-stage diagnosis rate is increasing at 27.6 percent annually. Among American Indian/Alaska Native populations, just 52.8 percent of women aged 40-74 reported receiving a mammogram within the preceding two years. Although the female population of those communities represents just 10.3 percent of the adult female population within the Affiliate service area, these data suggest the need for targeted interventions within these populations.

Through a health system analysis and qualitative data-gathering, the Affiliate sought insight to answer the following key questions:

1. Despite a perceived prevalence of breast health providers in these counties, what are the largest barriers to regular screening among medically underserved communities?
2. What interventions could decrease late-stage diagnosis rates in the region?

Because of the large total population within these Front Range counties, Komen Colorado will narrow its interventions in these counties to:

- Populations whose late-stage diagnosis trend rate is significantly higher or whose mammography screening percentage is significantly lower than the Affiliate service area as a whole; and
- Individuals with lower incomes who are uninsured or underinsured and who live in medically underserved or rural areas within the counties, households with incomes less than 250 percent of the federal poverty level, or linguistic isolation; are foreign-born; or have lower educational attainment than the Affiliate service area.

To provide breast cancer screening, diagnostic, and treatment care to the 404,941 women aged 40-64 living in those counties as of 2010, 136 screening providers, 52 diagnostic providers, and 27 surgical, medical, or radiation oncology providers were identified by the Affiliate's analysis of the health system within its service area. While interviews with Front Range providers revealed a more comprehensive and more complex health care system than what is available in the rural northeast or the Mountain and Resort regions, the greater number of available resources does not mean sufficiency to meet need among un- and underinsured communities.

Navigating the Front Range health care system becomes more complicated depending on insurance status. Many providers for the insured are linked to a particular insurance network, and other providers may limit the number of Medicaid/Medicare patients they see. For patients who are unfamiliar with the health care system, the need to visit different facilities that each have different financial-assistance qualification protocols can be overwhelming. Front Range providers emphasized the need for patient navigation. In addition, low-income, and particularly undocumented, workers in this region have little ability to negotiate time off work for an appointment, and risk losing wages for any time that is taken (Table 5.1). While public transportation is more widely available, it often requires more time and making multiple connections.

Additionally, some providers pointed to psychological or knowledge-based barriers, such as fear and misinformation, preventing patients from seeking care. Many fear the costs of care, and may refuse treatment or fail to seek care because they assume they cannot afford it. Many patients and providers are not aware of the financial resources that may be available, and others may feel there is a stigma associated with accepting assistance.

Many of the underserved are foreign-born, including refugee populations from various countries, as well as immigrants, both documented and undocumented. Barriers for these groups are compounded for those who speak a language other than English or Spanish. Unfamiliarity with the concept of preventive care, and certain taboos about breasts, also were identified as contributors to late-stage diagnoses among these populations.

Key Findings: Rural Northeast Colorado

Komen's Colorado's designation of rural northeast Colorado includes Logan, Morgan, Phillips, Sedgwick, Washington and Yuma Counties. As of 2010, the rural region had an estimated population of 11,051 women aged 40-64, a demographic projected to increase by 2.4 percent by 2020. Because of the rural nature of the region, county-specific breast cancer data are often too small to analyze. However, regional analysis by the Colorado Cancer Registry calculated the 5-year estimated annual percent change in female breast cancer deaths is rising by 9.9 percent. In addition, the counties in this region have an older female population, higher poverty, and lower Women's Wellness Connection screening percentages compared to the Affiliate service area.

Through a health system analysis and qualitative data-gathering, the Affiliate sought insight to answer the following key question:

1. What are the nuances related to the limited number of breast health care providers in this region that contribute to low screening percentages in this region?

Limited access to medical facilities, exacerbated by economic barriers to care for low-income and uninsured individuals, makes it difficult for women to access or remain in the breast cancer continuum of care within this region. Residents in these counties are particularly affected by transportation/distance-to-care barriers, with some women needing to travel up to 100 miles to access surgical, radiation, or medical oncology services if diagnosed with breast cancer. For those who are uninsured or underinsured and need charity care, often the travel required is even farther.

Breast health providers also identified a regional predisposition against preventive care as a barrier both for the older farmer/rancher residents of this region and for immigrant residents. Residents' immigration status and lack of health insurance also were identified as barriers to care in the region. Although preliminary enrollment data from Medicaid expansion and the first year of purchase of private plans through Colorado's health care marketplace indicate a decline in the region's uninsured population, breast health providers in the community did not report experiencing an increase in patients seeking preventive care. However, because undocumented immigrants are ineligible for public insurance programs or private plans, lack of insurance is expected to remain a barrier for this population.

Qualitative research also revealed provider organizations serving rural northeast populations were less likely than providers in some of the other regions to provide education about breast health/health care generally (Table 5.1). It was also less common for patient navigators in this region to be required to go through training.

Key Findings: Mountain and Resort Towns

Komen Colorado considers residents of Clear Creek, Eagle, Garfield, Gilpin, Park, Pitkin and Summit Counties as one target community because of common characteristics that inhibit residents' ability to access breast health care services. The counties are characterized by isolated mountain and resort towns, or sporadically developed residential communities in unincorporated parts of the counties, that depend on tourism for their economies.

A number of factors that adversely affect overall breast health outcomes are prevalent within these counties, including: an aging female population; rural, isolated communities; high costs of living that reduce lower-income residents' disposable income to allocate to breast health crises; linguistic isolation; residency barriers in some counties; and the overall lack of medical services for low-income and uninsured individuals. County-level breast cancer data are either unavailable or suppressed because of the small numbers. Relevant available data includes:

- Garfield County has significantly lower screening percentages than the Affiliate service area as a whole and has a late-stage diagnosis rate that is rising at 17.3 percent.
- Eagle County has a significantly lower WWC screening percentage than the State of Colorado, which is a concern considering the county's population of women aged 40-64 is expected to swell by 30.5 percent between 2010 and 2020.
- In Park County, only 55.6 percent of women between the ages of 40 and 74 report having had a mammogram in the last two years, and the county lost its lone primary care provider in summer 2014.
- Summit County is expected to experience a 20.5 percent increase in the number of women aged 40 to 64 between 2010 and 2020 – but has limited health care facilities.

- Clear Creek has a substantially larger female population between the ages of 40 and 64 compared to the Affiliate as a whole, is considered 100 percent rural and is also classified as 100 percent medically underserved.
- Pitkin County has a substantially larger female population between the ages of 40 and 64 than the Affiliate as a whole and 44 percent of the county is considered rural. Residents who live in Aspen, Snowmass Village or Basalt access care in Aspen – despite the lack of radiation oncology.

Through a health system analysis and qualitative data-gathering, the Affiliate sought insight to answer the following key questions:

1. What are the nuances related to the limited number of breast health care providers in this region that contribute to adverse breast health outcomes among certain populations?
2. How does regional cost of living act as a barrier to breast cancer care differently than in other regions within the Affiliate service area?

Interviews with providers from mountain and resort towns underscore barriers stemming from regional income inequality, where the already limited availability of providers is exacerbated for those with Medicaid or without insurance. The high cost of living in the area has also created a situation where those who are very low-income for the region are not considered low-enough income to qualify for Medicaid or financial assistance to offset health insurance expenses, yet they often cannot afford the monthly payments or out-of-pocket costs associated with even a high-deductible plan. Fear of health care costs was mentioned as a barrier to seeking or following-up with care by nearly all the providers in this region. The greatest needs in this region are affordable services for these populations, and financial support across the continuum of care for those who are underinsured.

Provider organizations serving larger mountain and resort town populations were the least likely to provide education about breast health compared to providers in other regions within the Affiliate service area. Of concern to the Affiliate was a recurring reluctance among providers in the region to conduct additional outreach because of questions about whether the region's breast health care system had capacity to support more patients.

Additional identified barriers include (Table 5.1):

- Limited facilities that provide care to low-income and uninsured individuals
- Fewer organizations reported that their patient navigators were required to attend training
- Patients in this region have to travel further, on average, than patients from Front Range communities to access diagnostic services and treatment
- A majority of the uninsured in this region are undocumented individuals
- Confusion about when to start breast screenings and how often to screen
- Transportation/distance-to-care barriers are compounded for low-income people who may have more difficulty securing time off work and may be less likely to have a vehicle capable of traveling mountain roads.

Providers in mountain and resort communities were more likely than other regions to have a full-time translator for their non-English-speaking patients.

Key Findings: Hispanic/Latina Women

Komen Colorado has selected Hispanic/Latina women as a target community because of lower screening percentages seen in these women compared to the Affiliate service area as a whole, as well as the presence of social determinants of health that adversely affect their breast health outcomes. While the Hispanic/Latina population in the Affiliate's service area experiences lower age-adjusted rates for breast cancer incidence, death, and late-stage diagnoses compared to non-Hispanic/Latina populations (Table 2.1), the trend for late-stage diagnoses is increasing at 5.9 percent among Hispanic/Latina women compared to just 1.8 percent for non-Hispanic/Latina women.

Hispanic/Latina populations comprise 21.2 percent of the Affiliate's service area – a percentage expected to increase through 2020 according to demographic forecasts. Overall, only 59.2 percent of Hispanic/Latina women in the Affiliate service area between the ages of 40 and 74 report having had a mammogram in the last two years – far below the rate of 70.8 percent of non-Hispanic/Latina women and the overall rate of 69.1 percent of women within the service area. Among women aged 50-74 within the Affiliate's service area, the self-reported screening percentage for Hispanic/Latina women in the last two years was slightly higher at 65.3 percent, although that percentage is still lower than the non-Hispanic/Latina rate of 74.2 percent and 73.2 percent for the Affiliate service area overall. Because early and regular screening has been demonstrated to increase detection of early stage breast cancer, these lower screening percentages among Hispanic/Latina women could contribute to the rising late-stage diagnosis rate among Hispanic/Latina populations.

Through a health system analysis and qualitative data-gathering, the Affiliate sought insight to answer the following key questions:

1. Do Hispanic/Latina women experience different barriers to care than their non-Hispanic/Latina counterparts?
2. How does immigration status inhibit some Hispanic/Latina women from entering or continuing through the breast cancer continuum of care?

In addition, an analysis from the Colorado Health Institute showed 58.1 percent of Hispanic/Latino adults in Colorado “have annual family incomes at or below 200 percent of the federal poverty level (FPL) - about 20 percentage points more than non-Hispanics.” Moreover, the 2013 Colorado Health Access Survey also revealed a 14.5 percentage-point gap in health insurance coverage between Hispanic/Latino and non-Hispanic/Latino Coloradans. These are issues of concern for Komen Colorado, as data from the 2012 Colorado Behavioral Risk Factor Surveillance System indicate that household income and insurance status also correlate to breast cancer screening percentages: 74.2 percent of women aged 40-74 above 200 percent FPL received a mammogram in the previous two years compared to less than 56 percent of those under 200 percent FPL, and 72.8 percent of women with insurance received a mammogram while just 38.3 percent of uninsured women reported doing so.

Qualitative data revealed that Hispanic/Latina women faced the same barriers to care as non-Hispanic/Latina women in each of the geographically based target communities. However, there are some additional issues for this population, including immigration status and language/cultural barriers (Table 5.1). While many providers have some form of Spanish-language services, there is still a need for more culturally sensitive care.

Since the passage of the Affordable Care Act, providers serving large Hispanic/Latina populations were least likely to report an increase in patients receiving breast cancer treatment, which might reflect how immigration status can interfere with treatment. Immigration status prevents some from seeking out care because this population fears being turned over to immigration authorities. Further, women who do not meet residency requirements do not have access to Medicaid, private insurance sold through Colorado’s marketplace, or other types of financial assistance.

Table 5.1. Most common barriers to receiving breast cancer care by target community

Target Community	Screenings	Diagnostics	Treatment
Medically Underserved Women in Front Range Counties	<ul style="list-style-type: none"> • Lack of knowledge about breast health • Fear of the diagnosis and/or treatment • Immigration status • Lack of knowledge that screenings are free for people with insurance • Prioritizing other family members’ health 	<ul style="list-style-type: none"> • Lack of insurance • Perceived cost of care • Fear of the diagnosis and/or treatment • Securing time off work • Transportation 	<ul style="list-style-type: none"> • Lack of insurance • Perceived cost of care • Transportation • Securing time off from work • Immigration status
Rural Northeast Colorado	<ul style="list-style-type: none"> • Knowledge about breast health • Lack of knowledge that screenings are free for people with insurance • Immigration status • Lack of insurance, and • Transportation 	<ul style="list-style-type: none"> • Fear of diagnosis and/or treatment • Lack of insurance • Distance to travel for specialty services • Immigration status • Lack of understanding of medical terminology • Securing time off from work 	<ul style="list-style-type: none"> • Lack of insurance • Immigration status • Perceived cost of care • Transportation • Distance to travel for specialty services
Mountain and Resort Communities	<ul style="list-style-type: none"> • Knowledge about breast health • Fear of diagnosis and/or treatment • Perceived cost of care • Lack of knowledge that screenings are free for people with insurance • Lack of insurance 	<ul style="list-style-type: none"> • Lack of insurance • Fear of diagnosis and/or treatment • Perceived cost of care • Transportation • Securing time off from work 	<ul style="list-style-type: none"> • Lack of insurance • Transportation • Distance to travel for specialty services • Perceived cost of care • Securing time off from work
Hispanic/Latina Women	<ul style="list-style-type: none"> • Immigration status • Fear of diagnosis and/or treatment • Lack of knowledge that screenings are covered without a co-pay or deductible for people with insurance • Lack of knowledge about breast health • Lack of insurance 	<ul style="list-style-type: none"> • Securing time off work • Lack of insurance • Immigration status • Fear of the diagnosis and/or treatment • Perceived cost of care 	<ul style="list-style-type: none"> • Immigration status • Lack of insurance • Perceived cost of care • Securing time off work • Transportation

Mission Action Plan

Critical analysis of strengths and weaknesses of the breast health care system that serves the above populations, as well as comprehensive qualitative research into unique barriers to breast cancer care faced by these populations, informed the Affiliate's selection of priorities through 2019. In identifying its priorities, the Affiliate considered:

- Could organizational allocation of philanthropic, educational/outreach, volunteer, and collaborative resources result in changes consistent with the intended outcome?
- Does the priority leverage the Affiliate's existing organizational strengths?
- Are there opportunities to leverage resources and expertise from existing or potential new partners?

The resulting priorities discussed below balance an overarching goal of improving breast health outcomes throughout the Affiliate's service area with adherence to the above considerations.

Medically Underserved Communities in Front Range Counties

Problem: Adams, Arapahoe, Broomfield, Denver, Douglas, Larimer and Weld Counties will be home to 70.1 percent of women aged 40-64 within the Affiliate service area by 2020. Rising late-stage diagnosis rates in the first six and a rising death rate in Weld County are cause for concern because of the large number of women who reside in these counties. Moreover, the late-stage diagnosis rate for Black/African-American women in Komen Colorado's service area is increasing at a rate of 8.9 percent annually - compared to an annual increase of 2.0 percent for the service area. Among Asian/Pacific Islanders, the late-stage diagnosis rate is increasing at 27.6 percent annually. Among American Indian/Alaska Native populations, just 52.8 percent of women aged 40-74 reported receiving a mammogram within the preceding two years. The health system analysis found more providers that provided services for the full continuum of care compared to other regions, but qualitative research indicated there was insufficient capacity to meet the need of the region's medically underserved communities. Interviews with health care providers identified lack of knowledge about breast cancer risk and how to navigate the health care system as top barriers contributing to late-stage diagnosis rates in their communities, but noted that transportation needs, fear, difficulty securing time off work, and lack of sufficient culturally competent providers for immigrant and refugee communities also contributed to late-stage diagnoses.

Priority 1: Reduce barriers that may contribute to late-stage diagnosis and/or lower screening percentages between Black/African-American, API and AIAN women and other ethnic groups.

Objective 1: By 2020, increase the requirement for organizations that receive screening/diagnostic grants to ensure 50 percent of individuals served are rarely/never screened women, including Black/African-American, Asian/Pacific Islander, and American Indian/Alaska Native women, an increase from a baseline of 35 percent of individuals served.

Objective 2: Beginning in FY16-17, solicit applications from eligible organizations to support culturally competent and linguistically appropriate breast cancer education and navigation-into-screening programs targeting Black/African-American, Asian/Pacific Islander, and American Indian/Alaska Native women in all counties where those

populations, in aggregate, comprise at least seven percent of the adult female population.

Priority 2: Increase income threshold for individuals to benefit from Affiliate-supported efforts to reduce cost, accessibility, and misinformation as barriers to breast cancer care for uninsured, underinsured, linguistically isolated, foreign-born or other medically underserved individuals in Front Range counties.

Objective 1: By 2020, increase the requirement for organizations that receive screening/diagnostic grants to ensure 50 percent of individuals served are rarely/never screened women, an increase from a baseline of 35 percent of individuals served.

Objective 2: By May 2016, evaluate Affiliate's community grant categories to assess whether applicants that provide screening, diagnostic and treatment services should be able to apply for a medical continuum of care grant rather than being required to apply for multiple direct service grants.

Objective 3: By June 2016, engage breast health care providers, WWC, and other key stakeholders in Colorado Health Statistics Regions (HSRs) 2 and 18; HSRs 3, 14 & 15; and HSRs 16 and 21; to evaluate perceived value of securing regional mobile mammography units to increase screenings among women living in medically underserved areas in Front Range counties.

Objective 4: By April 2016, evaluate capacity to provide breast health education, health insurance literacy, and "what to ask your provider" materials, in patients' preferred languages, to all community health centers, federally qualified health centers, imaging facilities, and cancer treatment facilities in the Affiliate service area.

Objective 5: By March 2016, partner with Denver-Metro, Larimer, Weld, and Boulder/Broomfield regional Komen coalitions to identify region-specific breast cancer barriers and develop collaborative strategy for resolution by 2020.

Mission Action Plan: Rural Northeast Colorado

Problem: Breast cancer death rates are increasing at an annual rate of 9.9 percent in rural northeast Colorado. The health system analysis found that breast cancer services were not readily available throughout the region. As a result, difficulties securing transportation to breast health providers and securing time off from work were identified as recurring barriers to care. Interviews with breast health providers indicated that lack of education about breast health and the scope of coverage for breast health services in insurance plans, as well as the prevalence of a predisposition against seeking preventive health care, exacerbated by the scarcity of providers, as barriers to improved breast health outcomes.

Priority: Reduce barriers that may contribute to increased breast cancer deaths in rural northeast Colorado.

Objective 1: By 2020, increase the requirement for organizations that receive screening/diagnostic grants to ensure 50 percent of individuals served are rarely/never

screened women, including women from Logan, Morgan, Sedgwick and Yuma Counties, an increase from a baseline of 35 percent of individuals served.

Objective 2: By May 2016, evaluate Affiliate's community grant categories to assess whether regional applicants that provide screening, diagnostic and treatment services should be able to apply for a medical continuum of care grant rather than being required to apply for multiple direct service grants.

Objective 3: By September 2015, work with Rural Solutions and the Northeast Colorado regional Komen coalition to assess effectiveness of current Affiliate funding to provide financial support to offset transportation costs for breast cancer care.

Objective 4: By December 2015, leverage Northeast Colorado Breast Health Coalition to re-engage breast health care providers, WWC, and other key stakeholders that serve rural northeast Colorado to evaluate potential impact for mobile mammography unit, financial assistance to offset transportation barriers, and other evidence-based interventions to address transportation/distance-to-care barriers in the region.

Objective 5: By December 2016, develop an education and outreach effort targeting regional primary care providers, community health resource centers, and/or individuals to provide continuous education about Komen-advised breast screening protocols.

Mission Action Plan: Mountain and Resort Towns

Problem: Higher costs of living and income gaps in mountain and resort communities often result in lower-income residents earning too much to qualify for Medicaid coverage but not enough to afford out-of-pocket expenses that come with commercial health insurance. As a result, cost of care remains a substantial barrier in the community. Moreover, limited breast health providers in the region accept Medicaid or provide charity care. In a region with limited providers overall, securing transportation to travel to those that do serve Medicaid clients or provide financial support adds another barrier to access. For the region's Spanish-speaking or foreign-born populations, language and immigration status also present challenges. These factors contribute to a region with substantially lower screening percentages than the Affiliate service area.

Priority: Increase affordable access to the full continuum of care by reducing cost and transportation barriers and increasing outreach/education for uninsured and under-insured populations.

Objective 1: By January 2016, evaluate Affiliate's provision of grant funding to offset costs for breast cancer treatment in Eagle, Garfield and Pitkin Counties and work with regional providers to determine future regional treatment needs, including funding to offset transportation-related expenses.

Objective 2: Beginning with the FY 16-17 grant cycle, increase income threshold for individuals in mountain and resort communities to benefit from Affiliate grant-funded projects to at least 300 percent FPL and annually evaluate capacity to increase threshold to 400 percent by 2020.

Objective 3: By 2020, increase the requirement for organizations that receive screening/diagnostic grants to ensure 50 percent of individuals served are rarely/never screened women, including women from Garfield, Gilpin and Park Counties, an increase from a baseline of 35 percent of individuals served.

Objective 4: By May 2016, evaluate Affiliate's community grant categories to assess whether regional applicants that provide screening, diagnostic and treatment services should be able to apply for a medical continuum of care grant rather than being required to apply for multiple direct service grants.

Objective 5: By June 2016, evaluate Affiliate's education and outreach program targeting Hispanic/ Latina populations in Eagle, Garfield and Pitkin Counties to understand impact on increase in screenings among rarely/never screened women, need for Spanish-only versus bilingual outreach, and whether there is sufficient overall and Komen-funded capacity to meet resulting demand for care.

Objective 6: By December 2016, develop an education and outreach effort targeting regional primary care providers, community health resource centers, and/or individuals to provide continuous education about Komen-advised breast screening protocols.

Mission Action Plan: Hispanic/Latina Women

Problem: The late-stage diagnosis rate for Hispanic/Latina women in Komen Colorado's service area is increasing at 5.9 percent annually compared to just 1.8 percent for non-Hispanic/Latina women and 2.0 percent for the service area as a whole. The health system analysis found that while more than 80 percent of screening, diagnostic and treatment providers that served Hispanic/Latina patients had Spanish-language translation services available, fewer than 40 percent of all providers within the Affiliate's service area offered that support, indicating a need for Spanish-speaking patients to be able to easily identify which providers can meet their linguistic needs. Health care providers that serve Hispanic/Latina patients indicated that while Hispanic/Latina women faced the same systemic barriers to care as their non-Hispanic/Latina counterparts in various regions of the Affiliate service area, immigration status and language/cultural barriers exacerbated those challenges.

Priority: Reduce barriers that may contribute to increased late-stage diagnosis rates among Hispanic/Latina women within Affiliate service area.

Objective 1. By 2020, increase the requirement for organizations that receive screening/diagnostic grants to ensure 50 percent of individuals served are rarely/never screened women, including Hispanic/Latina women, an increase from a baseline of 35 percent of individuals served.

Objective 2: Beginning in FY16-17, solicit applications from eligible organizations to support Spanish-dominant and bilingual breast cancer education and navigation-into-screening programs targeting Hispanic/Latina populations in all counties where Hispanic/Latina women comprise at least 25 percent of the adult female population or counties or health statistics regions where late-stage diagnosis rates among Hispanic/Latina women are substantially higher than their non-Hispanic/Latina counterparts.

Objective 3: By July 2016, incorporate third-party research findings about preferred languages for medical information among Hispanic/Latina communities into Affiliate's education efforts.

Mission Action Plan: Common Barriers Identified in All Target Communities

Problem: Qualitative data collection and evaluation of the effect of health care reform revealed barriers to care that affect target communities, suggesting a need for the Affiliate to develop global priorities and objectives for its grantmaking, education and outreach, public policy, collaboration and development efforts. These common barriers that contribute to late-stage diagnosis include:

- Immigration status
- Lack of insurance
- Fear of a diagnosis or lack of knowledge about breast cancer treatment
- Transportation/distance-to-care
- Securing time off work
- Perceived cost of care
- Screening-specific:
 - Lack of knowledge about breast health
 - Lack of knowledge about insurance coverage for screening procedures

Priority: Affiliate will engage in education, collaboration, and advocacy activities to ensure breast cancer perspective is considered by health-oriented or community foundations, policymakers, and other community stakeholders seeking to increase health care coverage, affordability, accessibility, and medically recommended utilization.

Objective 1: Partner with community stakeholders to achieve 90 percent insurance enrollment for all eligible populations by 2017.

Objective 2: By July 2016, develop plan to partner with philanthropic, business, government, and other nonprofit stakeholders to include breast cancer care in patient navigation, health care workforce development, and health care and health insurance literacy efforts benefiting Colorado's medically vulnerable communities.

Objective 3: By July 2016, Affiliate public policy and mission initiatives committees will develop a position statement on immigration status as a barrier to breast health care services.

Objective 4: By July 2016, Affiliate will develop and publicize position statements on poverty level and educational attainment correlating with mammography frequency in Colorado to highlight social determinants of health that contribute to late-stage diagnosis.

Objective 5: By July 2016, partner with American Cancer Society, Colorado Cancer Coalition, Colorado Department of Health Care Policy and Financing and other community stakeholders to identify resources to provide transportation assistance for cancer patients.

Objective 6: By December 2015, assess objectives in Breast Cancer portion of updated Colorado Cancer Plan to promote alignment within Affiliate’s grantmaking, education and public policy activities.

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Appendices

Appendix A. 2014 Federal Poverty Levels

Federally facilitated marketplaces will use the 2014 guidelines to determine eligibility for Medicaid and CHIP (this is effective February 10, 2014).

Household Size	100%	133%	150%	200%	250%	300%	400%
1	\$11,670	\$15,521	\$17,505	\$23,340	\$29,175	\$35,010	\$46,680
2	15,730	20,921	23,595	31,460	39,325	47,190	62,920
3	19,790	26,321	29,685	39,580	49,475	59,370	79,160
4	23,850	31,721	35,775	47,700	59,625	71,550	95,400
5	27,910	37,120	41,865	55,820	69,775	83,730	111,640
6	31,970	42,520	47,955	63,940	79,925	95,910	127,880
7	36,030	47,920	54,045	72,060	90,075	108,090	144,120
8	40,090	53,320	60,135	80,180	100,225	120,270	160,360

Source: Calculations by Families USA based on [data from the U.S. Department of Health and Human Services](#)

Appendix B. Inventory Tool for Continuum of Care Providers

Organization

Name: _____

Facility Street

Address: _____

City: _____ State: _____ Zip

Code+4: _____

Public Contact

Phone: _____

Facility URL/Website: _____

Do you have multiple locations?

No

Organization Type: *Please check all that apply.*

- Cancer Center
- City/County Health Department
- Community Based Organization
- Community Health Center
- FQHC
- FQHC Look-alike
- Free Clinic
- Hospice
- Hospital: Private
- Hospital: Public
- Imaging Center
- Rural Health Center
- Surgical Outpatient
- Women's Health Clinic
- Other: _____

Nonprofit:

Yes

No

If your organization has a separate foundation, please provide name and contact information below:

Development Director Name: _____

Phone Number: _____

Email: _____

Breast Health Navigator Name: _____

Phone Number: _____

Email: _____

Is there anyone else that we should contact at your organization to understand how your facility navigates patients/clients who have abnormal breast health symptoms? *If no one, please mark N/A.*

Name: _____

Phone Number: _____

Email: _____

What counties does your organization serve? _____

What type of breast health care services does you organization provide? *Please check all that apply.*

- Mammography (mobile – digital mammography): screening
- Mammography (mobile with tomosynthesis): screening
- Mammography (in-clinic): screening diagnostic
- Mammography (in-clinic with tomosynthesis): screening diagnostic
- Clinical Breast Exam (CBE)
- Patient Navigation into Diagnostics

- Genetic testing/counseling
- Ultrasound
- MRI
- Radiation
- Chemotherapy
- Surgical Consult
- Surgery
- Support Groups
- Side effect management
- Individual Counseling/Psychotherapy
- Financial Assistance
- End of Life Care
- Education on Family History/Breast Cancer
- Education on Abnormal Breast Changes
- Biopsy
- Patient Navigation Into Treatment
- Reconstruction
- Patient Navigation to Support Services
- Exercise/Nutrition Programs
- Complementary Therapies
- Legal Services
- Lifestyle Risk Factors for Breast Cancer (Obesity, Alcohol, Exercise)
- Other: _____

If you do not provide breast health care, where do you refer clients who need this service? _____

What protocols does your clinic follow to discuss symptoms and risk factors of ovarian cancer? (For example, age, family history, ethnicity or nationality, etc.) _____

The Colorado Ovarian Cancer Alliance has education materials and ovarian cancer survivor support resources; would you like to receive these materials to provide patients/clients?

- Yes
- No

What accreditations does your organization have? Please check all that apply.

- American College of Surgeons CoC Accredited
- American College of Radiology Breast Imaging Center of Excellence
- National Committee of Quality Assurance for Patient Centered Medical Homes
- American College of Surgeons NAPBC Accredited
- NCI Designated Cancer Center
- Other: _____

What types of payment does your organization accept? Please check all that apply.

- Self-Pay
- Medicaid
- Medicare
- CACP
- Veteran's/Military/TriCare
- Private Insurance
- Women's Wellness Connection
- Other: _____

Does your organization participate in any of the following? Please check all that apply.

- Colorado Accountable Care Collaborative
- Comprehensive Primary Care Initiative
- FQHC Advanced Primary Care Practice Project
- Medicaid Global Payment Initiative
- iCare for Rural Health/Critical Access Hospitals
- Other: _____

If your organization provides charity care, at what percentage % of Federal Poverty Level (FPL) do you provide it?

- 100% FPL
- 138% FPL
- 200% FPL
- 250% FPL
- 300% FPL
- Other: _____

Does your Federal Poverty Level population belong to any of the following categories? Please check all that apply.

- Lives in a mountain and resort region
- Latina/Hispanic
- Lives in a rural region
- Foreign-Born
- N/A

Thinking about your Clients/Patients from the past 12 months, what percentage of your clients/patients are foreign-born? _____

What percentage of your foreign-born clients/patients, fall into each of the categories below? (Some clients/patients may be included in multiple categories).

Legal Permanent Resident (Green Card Holder): _____

Legal Permanent Resident (Green Card Holder) for Less Than Five Years: _____

Temporary Visa Holders: _____

Otherwise Undocumented: _____

Mixed Document Households (i.e., some members of household are documented and others are not): _____

Besides English, what other languages do your patients/clients speak? _____

Appendix C. Online Survey of Breast Health Care Providers

Initial Email Invitation

From: [FIRST NAME LAST NAME]

Subject: Susan G. Komen® Colorado Requests Your Input

Dear [NAME],

We're conducting a survey of breast health care providers about their organization and the patients they serve, and we are asking for your participation. Your input will help guide Komen Colorado when making decisions about how best to serve breast cancer patients in their service area.

This survey takes only 15 to 20 minutes, and we ask that you complete it by [DATE].

To take the survey, please click here [AUTOLINK]. (or copy and paste the following link into your browser: [SURVEY LINK])

In case you are not logged in automatically, please use the following username and password:

Username: [USERNAME/EMAIL] (case sensitive)

Password: [4 DIGIT PIN]

Thank you in advance for your time.

Sincerely,

Beth Mulligan, *Principal*, Corona Insights

If you have any difficulty in accessing this survey, please contact Beth@CoronaInsights.com or at (303)894-8246.

Corona Insights, a Denver-based market research firm, was retained by Susan G. Komen Colorado to conduct this survey. Your responses will be sent securely to Corona Insights for review. Corona Insights received your contact information from Susan G. Komen Colorado for the specific purpose of this survey. Your contact information will not be used for any other purpose by Corona Insights, nor will be sold or otherwise distributed. Susan G. Komen Colorado and Corona Insights respect your privacy. To view our privacy policy please visit: <http://coronainsights.com/research-privacy-policy/>.

If you have additional questions or concerns about this survey or would like to verify its authenticity, please contact Toni Panetta, director of mission programs, at (303) 744-2088 ext 305.

To unsubscribe from future reminders for this survey, please click here [LINK].

Follow-up Email Reminder

From: Beth Mulligan

Subject: Share your knowledge and views on breast health services

Dear [NAME],

We recently asked if you had a few minutes to provide input to Komen Colorado. We know you are busy, but we really value your input, which will help guide Komen Colorado, the local Affiliate of Susan G. Komen, when making decisions about how best to serve breast cancer patients in the Affiliate's service area.

This survey takes only 15 to 20 minutes, and we ask that you complete it by [DATE].

To take the survey, please click here [AUTOLINK]. (or copy and paste the following link into your browser: [SURVEY LINK])

In case you are not logged in automatically, please use the following username and password:

Username: [USERNAME/EMAIL] (case sensitive)

Password: [4 DIGIT PIN]

Thank you in advance for your time.

Sincerely,

Beth Mulligan, *Principal*, Corona Insights

If you have any difficulty in accessing this survey, please contact Beth@CoronaInsights.com or at (303)894-8246.

Corona Insights, a Denver-based market research firm, was retained by Susan G. Komen Colorado to conduct this survey. Your responses will be sent securely to Corona Insights for review. Corona Insights received your contact information from Susan G. Komen Colorado for the specific purpose of this survey. Your contact information will not be used for any other purpose by Corona Insights, nor will be sold or otherwise distributed. Susan G. Komen Colorado and Corona Insights respect your privacy. To view our privacy policy please visit: <http://coronainsights.com/research-privacy-policy/>.

If you have additional questions or concerns about this survey or would like to verify its authenticity, please contact Toni Panetta, director of mission programs, at (303) 744-2088 ext 305.

To unsubscribe from future reminders for this survey, please click here [LINK].

Survey Instrument

Introduction

Susan G. Komen® Colorado is conducting a Community Profile to learn about services for breast health patients in the Affiliate's service area. This survey represents one component of the profile. If you have filled out the Breast Health Provider Inventory, some questions may seem familiar. Duplicated questions are only included in the present survey in order to guide you through it in a way that makes best use of your time.

As a provider of services for breast health patients in Colorado, your input is critical to understanding the issues and needs of our service area. The following survey should take about 15-20 minutes to complete. Thank you!

If you have any difficulty with this survey, please contact Beth@CoronaInsights.com or at (303) 894-8246.

About the Organization

1. Name of your organization _____
2. Your position within the organization
 - a. Nurse/nurse practitioner
 - b. Patient navigator
 - c. Physician. Please describe specialty/practice: _____
 - d. Physician's assistant
 - e. Medical Assistant
 - f. Radiology Technologist
 - g. Social worker/case manager
 - h. Community-based provider. Please describe: _____
 - i. Other. Please describe: _____

Services

3. Please indicate if your organization provides the following breast health and cancer care services. Please check all that apply.
 - a. Patient navigation
 - b. Mammography
 - c. Diagnostic services (e.g., ultrasound, biopsy)
 - d. Treatment
 - e. Patient support and follow-up

f. Education about breast health/health care generally

[Create variable]

a. if did NOT check a-d on Q3=CBO

b. Not CBO

4. [If patient support and follow up, not CBO] Please indicate if your organization provides the following non-medical support services for individuals with breast cancer or for breast cancer survivors. Please check all that apply.

a. Childcare while receiving services

b. Counseling services (including support groups)

c. Exercise or fitness programs specific for people with cancer

d. Financial assistance

e. Housing/utilities assistance

f. Food assistance/ nutritional guidance

g. Transportation to/from hospital or clinic

h. Other. Please describe _____

5. [If Q3=Yes, they have navigators, not CBO] Are the patient navigators at your organization required to attend training for patient navigation?

a. Yes

b. No

c. Unsure

6. [not CBO] What services, if any, do you think have been crucial to serving your breast cancer patient population?

7. What services, if any, do you think your organization could or should provide for breast health patients, but aren't currently providing? Why do you think it would be beneficial for your organization to add these services?

8. What guidelines does your organization follow for recommending a breast cancer screening?

a. Mammography every year starting at age 40

b. Mammography every one to 2 years starting at age 40

c. Informed decision-making with a health care provider for ages 40-49; then mammography every 2 years for ages 50-74

- d. Don't know
 - e. Other. Please specify_____
9. [If they do not provide mammography on site] Please estimate the number of referrals for mammograms your organization made in the last 12 months.
- a. _____
10. [If no mammography] Where do you refer clients/patients? Check all that apply.
- a. Hospital
 - b. Freestanding imaging center
 - c. Mammography van
 - d. Don't know
 - e. Other. Please specify_____
11. [If yes mammography, not CBO] Please indicate what type of mammography equipment your organization uses. Please check all that apply.
- a. Analog
 - b. Digital
 - c. Tomosynthesis
 - d. Unsure
12. [If yes mammography, not CBO] In the last 12 months, approximately how many mammograms did your organization perform?_____
13. [If yes mammography, not CBO] Of the mammograms provided in the last 12 months, approximately what percent of clients/patients needed follow up diagnostic services?_____
14. [If yes mammography?, not CBO] In the last 12 months, approximately what percent of your organization's clients/patients that received breast cancer Screening and/or Diagnostic Services were men?_____
15. [If no diagnostic services, not CBO] Where do you refer client/patients for diagnostic services? Check all that apply.
- a. Hospital
 - b. Freestanding imaging center
 - c. Don't know
 - d. Other. Please specify_____
16. [If they do not provide treatment/diagnostic services, not CBO] How far do people from your

community have to drive to get the services they need?

- a. Diagnostic services _____ miles
- b. Surgery _____ miles
- c. Chemotherapy _____ miles
- d. Radiation Therapy _____ miles
- e. Hormone Therapy _____ miles

Patients

17. To what extent do you perceive the following as barriers that prevent people in your community from getting preventive breast cancer screenings, from receiving diagnostic testing after an abnormal screening, and from receiving treatment after diagnosis?

	Barrier to receiving preventive care	Barrier to receiving diagnostic test after abnormal screen	Barrier to receiving treatment after diagnosis	Not a barrier
Prioritize other family members' health over self				
Lack of knowledge that preventive screenings are free for people with insurance				
Taboos about speaking/discussing breasts				
Taboos about speaking/discussing cancer				
Childcare needs				
Fear of the diagnosis and/or treatment				
Getting time off from work				
Transportation				
Distance to travel for specialty services				
Immigrant status				
Language barriers				
Lack of clinics or other facilities that provide routine screenings				
Stigma of going to a low cost/free clinic or organization				
Fear of being judged, talked down to, or other negative experience with a health care provider				
Limited clinic hours				
Perceived cost of care				
Lack of insurance				
Lack of knowledge about breast health				
Lack of knowledge of local clinic locations				
Lack of understanding medical terminology				
Cultural barriers (e.g., spiritual beliefs)				
Other. Please specify. _____				

18. [Show list of items they indicate are barriers.] Which of the following barriers would you say is the largest barrier overall?

	Biggest barrier to receiving preventive care	Biggest barrier to receiving diagnostic test after abnormal screen	Biggest barrier to receiving treatment after diagnosis
Any items from previous question that were marked as a barrier			

19. [not CBO] Since January 1st, 2014, have you experienced increases, decreases, or no changes in the following breast health patient groups?

	Increased	Decreased	No change	Don't know
Medicaid-covered patients				
Privately insured patients				
Uninsured patients				
Underinsured patients				
Patients receiving clinical breast exam or mammogram				
Patients needing breast diagnostic services				
Patients receiving breast cancer treatment				
Patients presenting with advanced stage breast cancer				

20. For breast health patients with Medicaid, what would you say are the barriers that those patients face when accessing breast health care?

21. For breast health patients with private insurance, what would you say are the barriers those patients face when accessing breast health care?

22. [not CBO] Please estimate for the past 12 months what percent of your organization's breast health clients/patients were in the following age groups:

a. Ages 18-26 _____

b. Ages 27-39 _____

c. Ages 40-49 _____

d. Ages 50-64 _____

e. Ages 65+ _____

23. [not CBO] Please estimate for the past 12 months what percent of your breast health clients/patients were from the following racial/ethnic backgrounds:

- a. Non Hispanic White/Caucasian
- b. Hispanic/Latino
- c. Non Hispanic Black/African-American
- d. Asian/Pacific Islander
- e. American Indian/Alaska Native
- f. Other. Please specify: _____

24. Recognizing that people may be in more than one group, please estimate for the past 12 months what percent of your breast health clients/patients were:

- a. LGBTQ: _____
- b. Men: _____
- c. Foreign born: _____
- d. Lived in resort or mountain communities
- e. Lived in rural communities

25. [not CBO] For non English-speaking clients or patients, how is information conveyed in clients'/patients' preferred language? Please check all that apply.

- a. Full time translator
- b. Part-time translator
- c. Written documents
- d. Tele-translator
- e. Translation-on-demand software
- f. Other. Please specify: _____

26. [not CBO] In the past 12 months did you collect documentation status data from your foreign-born patients?

- a. Yes
- b. No
- c. Don't know
- d. Didn't serve any foreign born patients

27. [If yes they collect documentation status, not CBO] How do you collect it?

-
28. [not CBO] Is your organization a Women's Wellness Connection (WWC) provider?
- a. Yes
 - b. No
 - c. Unsure
29. [Q28= not a WWC location, not CBO] What is your protocol for referring individuals to WWC?
- a. Call the WWC hotline
 - b. Send to local public health agency
 - c. Refer client to WWC Website
 - d. Don't refer
 - e. Don't know
 - f. Other. Please specify _____
30. [not CBO] Which of the following are eligibility requirements to enroll women diagnosed with breast cancer into the Breast and Cervical Cancer Treatment Program (BCCP)? Please check all that apply
- a. Has an income less than 250% of the Federal Poverty Level [true]
 - b. Is currently enrolled in Medicaid [false]
 - c. Does not have health insurance [true]
 - d. Has health insurance that does not cover breast or cervical cancer treatment [true]
 - e. Was diagnosed with breast or cervical cancer at a WWC location [false]
 - f. Lawful presence in the united states [true]
 - g. Must be age 40-64 [true]
31. [Q28= not a WWC location] Do you understand how to enroll someone in the Breast and Cervical Cancer Program (BCCP) for treatment if they were not diagnosed at a WWC location?
- a. Yes
 - b. No
 - c. Unsure
32. [If offer treatment, not CBO] If a breast cancer patient needs treatment but does not have the ability to pay, what is your facility's policy for serving this patient?
- a. Set up a payment plan for the full cost of services

- b. Reduce the cost of services based on income and set up a payment plan
 - c. Follow an internal hospital charity care policy
 - d. Turn the patient away
 - e. Don't know
 - f. Other. Please specify _____
33. [not CBO] Which of the following does your organization discuss with your clients/patients?
Please check all that apply.
- a. Alternative/complementary therapy such as acupuncture, massage, and mind-body medicine
 - b. Eligibility for financial assistance programs to offset breast health/breast cancer care expenses
 - c. Breast cancer survivorship plan
 - d. Pre-treatment counseling about side effects of breast cancer treatment such as lymphedema, chemo brain, sexuality/intimacy
 - e. Post-treatment counseling about side effects of breast cancer treatment such as lymphedema, chemo brain, sexuality/intimacy
34. Please indicate the counties your organization serves. Check all that apply.
- a. List of all Colorado counties
35. Please share any additional comments or concerns regarding breast health care for women residing in your service area.

Thank you for completing this survey. If you have any question about Susan G. Komen Colorado, please go to www.komencolorado.org for information about your local Affiliate.

36. Please check below if you would you like to receive:
- a. A copy of the Komen Colorado Community Profile
 - b. Requests for applications for grant funding from Komen Colorado
 - c. (if either are checked) What is your email address? _____

Appendix D. Phone Interview Guide for Breast Health Providers

Interviewee's Name:

Position/Organization:

Date:

Thank you again for taking the time to speak with us!

[For Corona Interviewers] As you may already be aware, our company, Corona Insights, is conducting research on behalf of Komen Colorado in order to better understand the current community strengths and needs related to breast health.

[For Komen Interviewers] As you may already be aware, Komen Colorado is conducting research in order to better understand the current community strengths and needs related to breast health.

As part of this effort Komen has conducted several surveys to gather information about the experiences and needs of organizations providing breast health care and support, and we are now following-up those surveys with interviews to gather more in-depth information about your experiences and needs. The interview will last about 25 to 30 minutes. Do you have any questions for me before we get started?

Great! I'd like to start out by asking some initial background questions so I can learn a little more about you and what you do.

[Interview Timing: Plan five min for Intro & Background Qs, 20 min for Community-Specific Challenges, five min for Partnership & Conclusion]

Background Questions

1. Can you tell me a little bit about your position at [organization]?
2. How long have you been in that position?
3. [Ask if not already expressed] What role do you play in providing breast health care or support?

Community-specific Challenges

4. How would you describe the community which your organization serves? What are some of the characteristics of your clients that make them unique relative to other organizations in Colorado (e.g. race/ethnicity, income/insurance status, age, immigrant status, LGBT, etc.)?

[For organizations serving two target regions – Hispanic and Mountain/Rural/Metro – first ask Q5 & 6 about their overall community, and then about their Hispanic Community.]

For the next few questions, I'd like to first ask you about your overall community, and then we will circle back and talk specifically about your Hispanic community.

5. In your community, what are the primary barriers to seeking breast health preventive care, diagnosis, or treatment? Are any of these barriers more prominent or different for the _____ (based on answer to #4) patients?

[If respondent lists more than 3-4 challenges, follow up with, "What is the most significant challenge for your community, or which one would have the largest impact if you could fix it?"]

[For each of the most significant challenges, loop through the following. Unless none of the most significant challenges match any of the probe categories, then ask Q5 only about the one most significant challenge, then move onto Q6 and then ask the probe questions that apply to the target region.]

[For orgs serving 2 target communities: go through Q5 once for the most significant challenge to community overall, then move onto Q6 for overall community. Then come back to Q5 for Hispanic community, go through once for most significant challenge to Hispanic community, then move onto Q6 for Hispanic community. Then ask any probe questions for Hispanic community that were not yet addressed. If more than five minutes remain at that point, ask additional probe questions for overall community.]

- What do you think could be done to reduce or eliminate [challenge]?
- What could Komen do to help reduce or eliminate [challenge]? [Probe for: advocate for particular policies? Educational campaign addressing X? Funding for X?]
- [Consult the Probe Questions below that correspond to the category of the most significant challenge mentioned and ask any that were not covered. Then circle back to discuss the next most significant challenge and so on.]
- [At 20 minutes into the interview, or after covering top three challenges, (whichever comes first), move on to Q6. If you finish Q6 with more than five minutes of time remaining, ask any probe questions that have not been covered, starting from the top of list.]
- ➔ How would you complete this sentence? If our community members _____, we would be able to catch breast cancers much earlier. [Listen for not being screened early enough? Not knowing risk? Not knowing behaviors that are relevant?]
- What would it take to make that happen?
- What could Komen do to help make that happen? [Probe for: advocate for particular policies? Educational campaign addressing X? Funding for X?]

Probe Questions by Topic

patient Navigation Services

[For Orgs providing Patient Nav Services; All Four Target Regions]

- Have you changed or considered changing the scope of navigation services provided at your facility? Please describe those changes.
 - Probe for changing from providing navigation services by clinical staff to advocates.
 - Probe for providing more financial counseling/insurance enrollment navigation vs. oncology navigation.
- What resources would you need to help make any changes you would like to make to your patient navigation services?

Financial Challenges [For all Four Target Regions]

- Our provider survey pointed to cost of care and lack of insurance as the most common barriers to breast health care. Could you describe how these barriers keep your community members from receiving the preventive care, diagnosis, or treatment they need? [Probe for specifics, if not provided. Do they have insurance but can't afford premiums, can't afford deductibles/copays, insurance doesn't cover needed procedures/treatments? Probe for how widespread the problem is among their patients.]
 - [If not mentioned] How would you describe your patient population's overall understanding about costs, how health insurance works, what breast health care services are covered through health insurance, where they can go for treatment, etc.? What are the most harmful misconceptions or gaps in knowledge that you encounter?
 - What is needed to reduce these barriers?
- Are there enough Medicaid providers to serve your patient population? [if no] What do you think would help increase the number of Medicaid providers in your area? [If org does not serve Medicaid patients] On our survey your organization indicated you do not serve Medicaid patients. Why not? What would it take to get you to accept Medicaid patients?

Knowledge/Literacy Barriers [For all Four Target Regions]

- How would you describe your patient population's overall literacy about breast cancer and breast cancer risk? What are some specific common misconceptions you have encountered?
- Our provider survey indicated that patients' fears often prevented them from seeking out or continuing with breast health care services. What fear do you believe represents the most significant barrier to receiving care among patients in your community? [Listen for fears about cost/inability to pay, fear of not being able to work, fear of dying.]
- [If not mentioned] Among your community members, what fears do you hear about loss of fertility, femininity, sexuality, or other quality of life concerns? How would you say those fears compare with the fears mentioned above? Are they more or less common? Compared to other fears, are they more or less responsible for keeping women from seeking or continuing with care?

Undocumented Populations [Ask of Hispanic-Serving Orgs]

- [If they serve undocumented immigrants] For patients without documentation, are there other barriers they face in addition to the ones we've discussed already? Are the other barriers exacerbated for them?

Transportation challenges [Ask of Rural- & Mountain-serving Orgs]

- [For people mentioning travel, distance, access to service issues] To what extent do you think telemedicine could reduce these barriers for your community? What other solutions would help reduce these barriers for your community?

Partnership with Komen

6. [If not already addressed] If funding wasn't an issue, how would you recommend resources be allocated to best overcome barriers to breast health care services among medically underserved communities in your area?
7. If you had to give Komen Colorado a grade for how well they are helping you meet your breast health population needs, what grade would you give them and why?

Conclusion

8. Do you have any final comments or suggestions for Komen Colorado?

Thank you so much for taking the time to speak with me. We know that your time is valuable, and your input and experiences are important to us.