COMMUNITY PROFILE REPORT 2015

SUSAN G. KOMEN®
SOUTHERN NEVADA

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Executive Summary

Introduction to the Community Profile Report

Susan G. Komen® of Southern Nevada was incorporated in the fall of 1996, following the first Race for the Cure® in Las Vegas. Since its inception, the Affiliate has grown and now serves the six southernmost counties of Nevada: Clark, Nye, Esmeralda, Lincoln, White Pine and Mineral. The Affiliate's service area is characterized for its rural communities, below average education levels and incomes under the national median with the exception of Clark County, which hosts the most populated urban center of the state with Las Vegas and surrounding cities. Clark County has an extremely diverse population with large numbers of minorities living in its cities. Furthermore, Clark County has a high percentage of undocumented populations.

Komen Southern Nevada is a small office with only three full-time staff members. A Board of Directors oversees all Affiliate operations. During the year 2014, the Affiliate set up an Advisory Board, which is comprised of former active board members. A group of approximately forty volunteers work for nearly ten months of the year on the Race Committee. Further, the Affiliate relies on a large volunteer base, without whom the Affiliate could not operate at the level at which it does currently. Since its inception in 1996, the Affiliate has raised over $7.7 million. These funds have been granted out to the community in the form of Community Grants and Small Grants, ensuring better breast health quality care for the uninsured and underinsured of Southern Nevada.

The information in this Community Profile will serve as an assessment of the local breast health community and will guide the following Affiliate activities:

- Drive inclusion efforts in the Southern Nevada breast health community
- Set granting priorities
- Advise on educational needs
- Strengthen message to the community and sponsors
- Establish methods of outreach in target communities
- Drive public policy efforts
- Serve as a tool for the Board of Directors and staff, community members, grantees, partners, sponsors and policymakers

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

This section was created by collecting data from several credible sources. Then the data were analyzed to determine how long it would take the Komen Southern Nevada service area to achieve Healthy People 2020 objectives of breast cancer late-stage diagnosis and death rates.

Overall, incidence rates in the Affiliate's service area were lower than US rates, however, trends were higher in the service area than national trends. On the other hand, there was no significant difference between the Affiliate service area and Nevada rates and trends. For the Affiliate area as a whole, the incidence rate was lower among Blacks/African-Americans than among Whites and lower among Asian-Pacific Islanders (APIs) than among Whites. Similarly, incidence rates were lower among Hispanic/Latina women than among Non-Hispanic/Latina women. There was not enough information to make a comparison with American Indian and Alaskan Native

individuals, or AIANs. Trends and rates in communities within the service area were similar to those of the service area as a whole.

Overall death rates in the Affiliate service area were similar to national rates. However, comparison for trends could not be done. Affiliate service area death rate trends were similar to those of the state of Nevada. For the Affiliate's service area as a whole, death rates were higher among Blacks/African-Americans than Whites and lower among APIs than Whites. Not enough data were available for AIANs. Death rates were lower among Hispanic/Latina women than among Non-Hispanic/Latina women. None of the counties in the Affiliate service area had a significant difference in death rates from the Affiliate service area as a whole or not enough data were available for comparison. Similarly, trends were not different or could not be compared. Overall, the late-stage incidence rate observed in the Komen Southern Nevada service area was higher than US rates and trends were lower in the Affiliate's service area than national trends. For the Affiliate service area as a whole, late-stage incidence rates were slightly higher among Blacks/African-Americans than Whites and lower among APIs than Whites. Not enough information was available to make a comparison with AIANs. The late-stage incidence rate was lower among Hispanic/Latina women than among Non-Hispanic/Latina women. No counties in the service area had significantly different data or not enough data were available to make a comparison to the Affiliate service area as a whole.

Because having mammograms lowers the chance of dying from breast cancer, it's important to know whether women are having mammograms when they should. Breast cancer screening proportions in the Affiliate service area were not significantly different than national data. For the Affiliate's service area as a whole, screening proportions weren't significantly different among Blacks/African-Americans and Whites nor among APIs and Whites. Not enough information was available to make a comparison for AIANs. The screening proportion among Non-Hispanic/Latina women was not significantly different than among Hispanic/Latina women. Screening proportions in the counties inside the Affiliate service area were similar to the Affiliate service area as a whole or not enough data were available.

The Affiliate service area has a diverse population with a slightly lower percentage of White, Black/African-American and AIAN women than the US average and a substantially higher percentage of APIs and Hispanic/Latina women. Both education and average age of women in the Affiliate service area are below the national average. On the other hand, unemployment percentages are above the national average. Income, however, is similar to national data. Counties in the Affiliate service area are quite different and diverse among themselves in terms of demographic data.

Healthy People 2020 (HP2020) is a major federal initiative that provides specific health objectives for communities and for the country as a whole. Some of these objectives are breast cancer related, such as reducing death rates per 100,000 women and reducing late-stage diagnosis per 100,000 women. This report calculates how long it will take for communities in the Affiliate's service area to reach HP2020 objectives based on rates and trends. 2008 was used as the starting year, thus assuming that every community has 12 years to reach their objectives. If a community takes more than 12 years, then they are not meeting targets on time.

Nye County has the highest priority, followed by Clark County. Not enough information was available to determine level of priority for the remaining four counties in the Affiliate's service

area. Although a county may have high priority, trends can change between now and 2020 and, therefore, targets may be met. Some of the factors that affect changes in trends are improving screening programs or improving socioeconomic barriers for minority populations. This report identified Nye County as a Highest Priority Area. Nye has an older population, as well as high poverty and unemployment percentages. Clark County was identified as a high priority area.
In order to identify target communities, the Community Profile Team not only looked at HP2020 data, but also at the following indicators:

- Incidence rates and trends
- Death rates and trends
- Late-stage rates and trends
- Below average screening percentages
- Residents living below poverty level
- Residents living without health insurance
- Unemployment percentages
- Residents who are linguistically isolated and/or foreign born

Through the thorough analysis of all these data, the Team identified three target communities:

- Clark County, Nevada (Las Vegas Ward 3 and Ward 5)
- Clark County, Nevada (North Las Vegas)
- Nye County, Nevada

With a population over two million and 70.0 percent of the state's residents, Clark County is the most populous county in Nevada. Between the years 2005-2009, 1,487 new breast cancer cases were diagnosed in the state of Nevada, 1,020 of which were detected in Clark County. Clark County is expected to meet the HP2020 breast cancer death rate target partially due to a decreasing annual trend of -1.5 percent. On the other hand, it is likely to miss the late-stage incidence rate with an increasing annual trend of 1.6 percent. Although screening percentages in Clark County (75.3 percent) are higher than Nevada's (73.1 percent), they are still below the national average (77.5 percent). The city of Las Vegas is divided into six wards. Wards 3 and 5 were selected as target communities because they were considered very low-income areas that experience some of the worst rates of disease, unemployment and health insurance participation.

Las Vegas Ward 3 is composed of mostly younger individuals, with 61.5 percent of residents between the ages of 18 and 64. This ward is home to the highest percentage of Hispanics/Latinos in the city (63.0 percent of residents). 38.2 percent of residents speak a language other than English and median household income is $34,161, much lower than the city's median ($54,174). Further, Ward 3 is home to the highest percentage of individuals under the poverty line (27.4 percent) and it has the highest unemployment level in the city at 15.5 percent. Las Vegas Ward 5, on the other hand, has a more evenly distributed population in terms of race and ethnicity; roughly 30 percent are White, 39.5 percent are Hispanic/Latino and about 20 percent are Black/African-American. Ward 5, much like Ward 3, is quite young with 62.7 percent of the population between the ages of 18 and 64. Approximately 38.2 percent of residents speak a language other than English. 66.6 percent of Ward 5 residents are in the labor force and 24.4 percent of individuals live below the poverty line.

The City of North Las Vegas was selected as a target community because of the percentage of residents that are foreign born, linguistically isolated and living below the federal poverty level. According to the 2010 US Census Bureau, North Las Vegas is diverse with 47.4 percent of residents being White, 38.8 percent are Hispanic/Latino and 20 percent are Black/African-American. Over 20 percent of North Las Vegans are foreign born and roughly 40 percent speak a language other than English in the home. Over 15 percent of residents live under the poverty level and, as of 2014, unemployment was over 15 percent, which is above the national average.

The population in Nye County is over 90 percent White and 13.4 percent identified as Hispanic/Latino. Median household income is $39,150 with 20.5 percent of the population living below 100 percent of FPL, 15.6 percent of the population is unemployed and 35.3 percent of individuals living in designated rural areas. Death rate trends data were not available for this county; however, the county's death rate (24.4 per 100,000) is higher than the state of Nevada and the US rates. With an increasing late-stage annual trend (2.7 percent), Nye County is likely to miss the HP2020 late-stage incidence rate target.

Health System and Public Policy Analysis

Target communities in Clark County have relatively good screening services if a woman is only seeking a clinical breast exam (CBE). Patient navigation is also readily available at this level of the continuum of care. Mammography screenings are harder to come by, especially for those individuals with no health insurance. North Las Vegas has two facilities that offer mammograms, however, one of them is a VA hospital and is not open to the general public. Las Vegas Ward 3 has two facilities where mammograms are offered. Las Vegas Ward 5 has no mammography facilities. Diagnostic facilities are even less frequent and, if a mammogram presents abnormal results, patients will be required to travel to other parts of the city for follow-up tests. There are only three treatment facilities in the Las Vegas valley and none of them are located within the target communities. Survivor support services are practically nonexistent and individuals must travel to other parts of the city to access them. Since individuals in the target communities have low incomes, there is a high likelihood they do not have free access to a private vehicle and a 15-mile trip can become a three-hour ordeal each way using public transportation. Furthermore, perhaps due to cultural diversity, not every resident in Clark County receives adequate breast health care, either because medical providers are not culturally sensitive or because they do not speak the language of their patients. This presents an even greater problem to the undocumented population, who may not seek medical attention for fear of being reported to Homeland Security.

Nye County is extremely rural, with two main urban centers in Pahrump and Tonopah. Most health care facilities, with the exception of one, are located in these two urban centers. Community health clinics, which are the predominant form of health care facilities in this county, are staffed with nurses only, so the CoC ends after a clinical breast exam. There are two health care facilities that offer mammograms, however, if an anomaly is found, individuals are sent to Las Vegas or California for follow-up exams and treatment. The county health departments in Pahrump and Tonopah offer financial assistance for those patients who need to travel for follow-up tests and treatment. However, women in this community need to travel long distances, even for screening.

Women's Health Connection (WHC), Nevada's version of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), is a CDC grant managed by Access to Health care Network (AHN). This program provides free screening for qualifying women. WHC is one of the most restrictive programs in the nation. Because it is underfunded, receiving only CDC funds, the program has set forth age restrictions (only women ages 40-64 will be screened and only those who are 50+ will receive a yearly mammogram) and income restrictions (women must be at 250 percent of FPL or below). Further, if a woman is diagnosed at a non-WHC approved center, she will not be eligible for WHC services, including fast-tracking to Medicaid. A woman will only be enrolled in Medicaid during her treatment if she fulfills all Medicaid enrollment criteria. Finally, this program does not provide any survivorship treatment services.

Nevada's Comprehensive Cancer Coalition is a nonprofit collaboration between state and local governments, health, medical and business leaders, the research community, cancer survivors, caregivers and advocates. Nevada's Comprehensive Cancer Plan has five fundamental goals:

- Reduce the risk for developing cancer
- Increase early detection and appropriate screening for cancer
- Increase access to appropriate and effective cancer treatment and care
- Address quality of life issues for health care consumers affected by cancer
- Improve the coordination and collaboration between cancer control efforts

Although the Coalition is quite active in the northern half of the state, it is not as active in Southern Nevada. Komen Southern Nevada is part of a steering committee that hopes to accomplish a more cohesive and comprehensive network of cancer care in Southern Nevada.

Under the Affordable Care Act (ACA), Nevada has expanded Medicaid to 138 percent of FPL. Additionally, Nevada created a state marketplace, the Nevada Health Link, where individuals can purchase insurance under the ACA. 2014 Kaiser Foundation estimates state that the number of uninsured individuals will drop from 27.0 percent in 2013 to 19.6 percent after Medicaid expansion and the implementation of the ACA. State sources, on the other hand, calculate that one third of uninsured individuals will be eligible for Medicaid and the remaining two thirds will be able to sign up for health insurance through the Exchange. However, the latter statistics do not take into account undocumented populations, who are not eligible for Medicaid or ACA subsidies, or those families and individuals who choose to pay the penalty rather than purchase health insurance.

The large influx of patients that were previously uninsured has offered its own set of challenges within the health care system. Some of these challenges include: 1) educating and enrolling the insurance eligible population, 2) expanding Medicaid Services to absorb the Medicaid expansion and 3) increased provider demand and, in some areas, provider shortages.

After Medicaid expansion, women who are between 139 percent and 250 percent of FPL are eligible for WHC. Preliminary data estimates that, of those enrolled with WHC, 45 percent are eligible for Medicaid and 5 percent are eligible for the Nevada Health Link. Although Medicaid expansion and the ACA, in theory, lower the patient load for WHC, numbers are still high. In fact, during 2014, the program did not observe a decrease in their screening numbers. Because open enrollment is limited to a short period of time, individuals who did not sign up for insurance during the open enrollment fall through the cracks. AHN is making an effort to engage all of their eligible clients to sign up for a plan under the ACA.

During the open enrollment period for 2014, Nevada Health Link experienced a series of technical difficulties. Therefore, it was decided that, going forward ~~forth~~, health care.gov would handle the Silver State Exchange. However, Nevada will still have a marketplace and premiums will be paid directly to insurance companies, while HHS will simply process applications.

Although it was expected that Medicaid expansion and the ACA would result in large numbers of health insurance enrollment, 2014 data shows that that was not the case. A large number of individuals remain uninsured as being eligible for something does not mean automatic enrollment.

Looking forward, the Affiliate foresees a need for patient navigation as a large number of individuals who did not have access to health care are now enrolled. As the ACA does not look at survivorship services, the Affiliate will need to pay attention to said services as well.

Qualitative Data: Ensuring Community Input

During the qualitative data collection, the Community Profile Team hoped to answer the following questions:

- Do individuals in the target communities have knowledge of breast health and risk reduction behaviors?
- Does an individual's place of residence alter their understanding of breast health?
- What are the main barriers stopping individuals in the target communities from accessing breast health care?
- What are the best ways to reach individuals in the target communities?

In order to obtain this data, the Community Profile Team utilized several data collection methods, including the distribution of 223 short surveys, both in Spanish and English, by four breast health organizations and community partners. Through these surveys, the Team sought to understand individuals' knowledge about breast health and how to best approach women in target communities. Eight key informant interviews were carried out with breast health professionals who either resided in the target communities or offered services to individuals from the target communities. The purpose of the interviews was for the Team to learn about effects of the ACA, perceived barriers to health care and best practices. The Team also organized two survivor focus groups during which individuals discussed their experience with health insurance and navigating the health care system. Finally, the Team performed a literature review to hopefully better understand the situation in communities where other qualitative methods were difficult to carry out.

North Las Vegas, Clark County

The main barrier to mammography screenings in North Las Vegas is lack of health insurance and that women do not think it is necessary. The majority of women who received a mammogram did so under medical advice, thus emphasizing the importance of health care providers in educating individuals. Due to the cultural diversity of this city, it is important to also provide culturally sensitive classes for patients and classes in cultural competence for health care professionals.

Las Vegas Ward 3 and Ward 5, Clark County
Much like North Las Vegas, Ward 3 and Ward 5 also present the barrier of lack of health insurance as the primary reason why women do not access mammography screenings. Also similar to North Las Vegas, Las Vegas Ward 3 and Ward 5 residents rely on their health care providers to let them know when to get a mammogram. Individuals in this community feel as if they lack education. Health fairs and health care providers should be utilized as a point of contact to encourage individuals to attend health workshops.

Nye County
Nye County has the most elderly population in Nevada, thus increasing their need for medical services due to their personal risk factors for breast cancer. However, due to the rural nature of the county and outmigration of younger generations, services are few and far between. Most individuals need to travel long distances to Las Vegas or California for health screenings. Nye County is also ranked as one of the unhealthiest counties in Nevada, mostly due to social factors such as education and unemployment percentages. Therefore, because of the lack of public transportation, education and resources, individuals do not necessarily have health insurance or they do not access health services due to distance and barriers to transportation. Relationships with their primary health care providers are viewed as an important asset for positive health results and breast cancer patients' value said relationships highly. Unfortunately, in order to access treatment, patients must travel long distances and this is the major cause of stress among breast cancer survivors and co-survivors.

Mission Action Plan

Nye County
Problem Statement: Nye County has high late-stage diagnosis rates. According to the quantitative data, 72.3 percent of women ages 50-74 reported having had a mammogram in the past two years. This might be due to the fact that, according to the health systems analysis data, the CoC often ends after a CBE and patients need to travel long distances for mammograms or follow-up tests. The qualitative data suggests that the lack of public transportation in Nye County, the lack of health insurance and high levels of poverty are a major deterrent for men and women to have regular mammography screenings.

Priority 1: Increase regular mammography screening percentages in Nye County by strengthening the Affiliate's current partnership with the Nevada Health Centers Mammovan, the health departments in Pahrump and Tonopah and the community nurses' clinics.

> *Objective 1:* By December 2015, arrange a meeting with at least three stakeholders to create an action plan that will ensure regular visits of the Mammovan throughout the county so that women who wish to get a screening mammogram do not have to drive for more than an hour each way.
>
> *Objective 2:* By May of 2016, distribute a comprehensive community contact list with key individuals that can assist marketing the Mammovan in at least five communities in Nye County in cooperation with Nevada Health Centers and the health departments in Pahrump and Tonopah.

Objective 3: By December 2016, encourage the Mammovan to expand their visits to Nye County by at least one additional event by providing assistance with finding contacts in the communities and advertising the arrival of the Mammovan.

Objective 4: By the end of FY 2018 create an evaluation plan in cooperation with the Mammovan and the health departments in Pahrump and Tonopah that will analyze the Mammovan's efficacy in reaching new clients and retaining old ones in at least five visits during the following fiscal year.

Priority 2: Eliminate barriers that impede women with suspicious mammograms in moving along the CoC.

Objective 1: Review the travel scholarship small grant that was awarded to the health department in Pahrump by Komen Southern Nevada and determine how many individuals benefited from it in order to determine its continuity by January 2016.

Objective 2: The FY2016 Small Grants Request for Application (RFA) will include programs that provide transportation services for residents of Nye County to receive breast cancer services as a funding priority.

North Las Vegas and Las Vegas Wards 3 and 5, Clark County

***Problem Statement*:** As the most diverse county in Nevada, many residents of North Las Vegas and Las Vegas Wards 3 and 5 do not receive culturally appropriate medical care, which causes trends in late-stage diagnosis to be higher than national trends. The quantitative data indicates that over one in five residents in North Las Vegas are foreign-born and about 40.0 percent of individuals in North Las Vegas speak a language other than English in the home, which indicates a high level of cultural diversity. Las Vegas Ward 3 is home to the largest percentage of Hispanics/Latinos in the City of Las Vegas. Unfortunately, a large portion of the population is undocumented. The health systems analysis data shows that there are limited options for mammography screenings in North Las Vegas, in particular, for those individuals who do not have health insurance. There is the need to travel to different parts of the city for screenings. Furthermore, the qualitative data suggests that due to lack of understanding of the US health care system, men and women do not access preventive health care services, but rather go to the emergency room when there is no other option.

Priority 1: Increase culturally sensitive outreach by providing small group information workshops to individuals of different cultural/ethnic backgrounds in cooperation with local organizations in North Las Vegas and Las Vegas Wards 3 and 5.

Objective 1: By December 2015, identify at least three organizations that work with ethnic minorities in North Las Vegas and Las Vegas Wards 3 and 5 who can assist with outreach efforts to ethnic minorities.

Objective 2: Recruit at least five volunteers from North Las Vegas and five volunteers from Las Vegas Wards 3 and 5 that speak a language other than English and train them on Komen BSA messaging by March 2016.

Objective 3: By 2017, form at least three partnerships in North Las Vegas and three partnerships in Las Vegas Wards 3 and 5 with predominantly Hispanic/Latino, Black/African-American and Asian associations where BSA messaging can be promoted (i.e. religious organizations, cultural groups, schools, etc.).

Objective 4: In FY 2018, hold at least four culturally sensitive workshops in North Las Vegas and Las Vegas Wards 3 and 5 that are aimed specifically at navigating the health care system for breast care in cooperation with local organizations.

Priority 2: Enhance cultural competencies of health care providers throughout the Las Vegas Valley that provide services to resident of North Las Vegas and Las Vegas Wards 3 and 5.

Objective 1: In FY 2016, identify and contact at least three health organizations that provide services to residents of North Las Vegas and Las Vegas Wards 3 and 5 that are culturally competent and serve a diverse population.

Objective 2: In cooperation with the aforementioned organization(s), hold at least four cultural competency workshops for health care providers that provide breast cancer services for residents of North Las Vegas and Las Vegas Wards 3 and 5 during FY 2017 and FY 2018 (two workshops per fiscal year).

Priority 3: Increase the number of health services and providers available in North Las Vegas and Las Vegas Wards 3 and 5 by funding health system partnerships to increase access to services.

Objective 1: By December 2015, hold at least two grant writing workshops in North Las Vegas and Las Vegas Wards 3 and 5 aimed at existing breast health providers identified on the resource map to inform the providers of potential funding opportunities.

Objective 2: For FY 2016, the Community Grant Request for Application (RFA) will include patient navigator programs aimed specifically at working with minority populations and linguistically isolated individuals living in North Las Vegas and Las Vegas Wards 3 and 5 as a funding priority.

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

Introduction

Affiliate History

Nancy G. Brinker promised her dying sister, Susan G. Komen, she would do everything in her power to end breast cancer forever. In 1982, that promise became Susan G. Komen® and launched the global breast cancer movement. Today, Komen is the world's largest grassroots network of breast cancer survivors and activists fighting to save lives, empower people, ensure quality care for all and energize science to find the cures. Thanks to events like the Komen Race for the Cure®, Susan G. Komen has invested more than $2 billion to fulfill Komen's promise, becoming the largest source of nonprofit funds dedicated to the fight against breast cancer in the world. For more information about Susan G. Komen, breast health or breast cancer, visit www.komen.org or call 1.877.GO KOMEN.

Susan G. Komen of Southern Nevada was incorporated in the fall of 1996 following the first Race for the Cure to bring the Komen promise to Las Vegas and surrounding areas. Today, the Komen Southern Nevada Affiliate serves Clark, Nye, Lincoln, Esmeralda, White Pine~~,~~ and Mineral Counties. Having invested over $7.1 million in the local community since inception, Komen Southern Nevada is clearly a leading funder in the local breast cancer community. The Affiliate is a leader in the local community as an active member of the Nevada Cancer Coalition and a partner with other organizations throughout Southern Nevada who offer screening services, education and outreach and support services to survivors.

Komen Southern Nevada provides community grants, which last one fiscal year and are geared towards programs that enhance access to screening and treatment, education and survivor support services for the medically underserved. Furthermore, the Affiliate is proud to also fund small grants of up to $10,000 during the year. These small grants provide the funding for pilot programs, education and outreach projects, travel scholarships to attend conferences, etc. During FY 2015, Komen Southern Nevada granted over half a million dollars to five different programs ranging from screening services to financial assistance and counseling services for survivors.

Every October, the Affiliate publishes a Request for Application (RFA), which indicates Komen Southern Nevada's funding priorities for the following fiscal year's community grants. Nonprofits across Southern Nevada who provide breast health and breast care services are invited to apply for funding. A volunteer review panel formed by health care professionals, breast health and breast care experts, nonprofit workers and survivors review and rank all applications. Recommendations for funding are then submitted to the Board of Directors. Upon Board approval, grants are awarded and the project cycle begins on the first of April every year.

Affiliate Organizational Structure

Komen Southern Nevada is a nonprofit organization with all actions overseen by a volunteer Board of Directors (Figure 1.1). The Affiliate's Board of Directors consists of community members from a wide range of professions, businesses and areas of expertise. In 2014 an Advisory Board was implemented. The Advisory Board consists of former active Board members who continue to lend their expertise to the Affiliate as needed. Additionally, the

Affiliate has a committee of nearly forty volunteers who work for nine to ten months to organize the Komen Southern Nevada Race for the Cure.

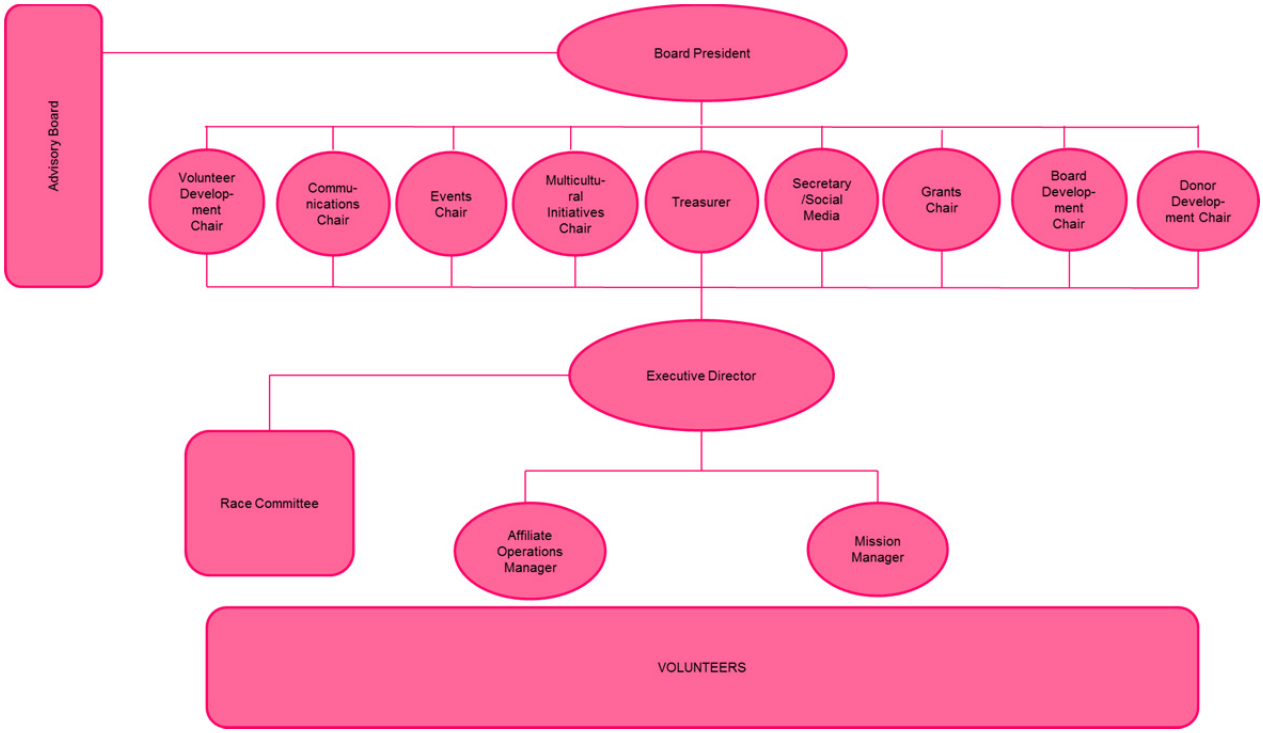


Figure 1.1. Susan G Komen® Southern Nevada organizational structure

In addition to the Board of Directors, the Affiliate has three staff members that include an Executive Director, who manages daily activities, a Development & Mission Manager and an Affiliate Operations Manager. With a small staff of three, volunteers are essential to all aspects of the Affiliate's operations.

Affiliate Service Area

Komen Southern Nevada serves Clark, Nye, Lincoln, Esmeralda, White Pine and Mineral Counties (Figure 1.2). The service area expansions of both Komen Southern Nevada and Komen Northern Nevada cover the entire state with Komen services.

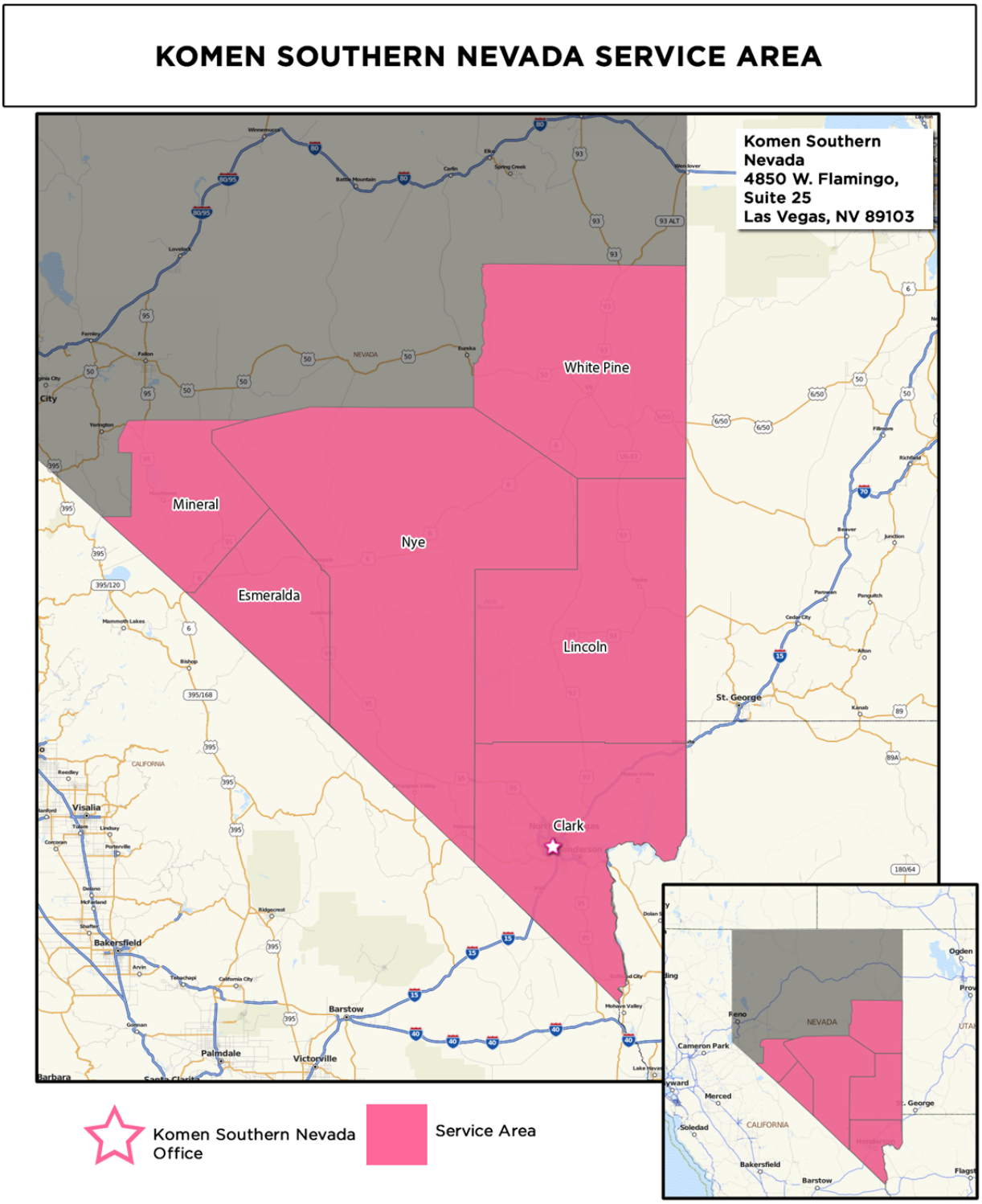


Figure 1.2. Susan G. Komen Southern Nevada service area

Nevada is the seventh largest state in the country with 110,567 miles of land. It is 485 miles long and 315 miles wide. According to the most recent census data (2010), Nevada is also the 35th least populous state. Most of the population in Nevada is concentrated in three counties; 89.9 percent of the state's population resides in the urban counties of Washoe, Carson City and Clark. By far, Clark County, in Southern Nevada, is the most populous region, containing 72.3 percent of the population (Table 1.1) (US Census, 2010). Nye County, on the other hand, is the

largest county by surface area; however, it contains only 1.6 percent of Nevada's total population (Nevada Aging and Disability Services Division, 2012). The least populated counties in Nevada contain only one person per five square miles (US Census, 2010). Nevada has the highest population increase in the country since the year 2000, with a population increase of 35.1 percent, in comparison to the national increase of 9.7 percent (US Census, 2010). Even though Nevada is one of the fastest growing states in the United States, it is also one of the most rapidly aging states. Nevada's population of adults age 60 and over increased by 56.3 percent, versus the national increase of 22.0 percent (Nevada Aging and Disability Service Division, 2012). Nevada seniors 85 years of age or older increased by 77.7 percent, versus a 29.75 percent increase of this group nationwide (Nevada Aging and Disability Service Division, 2012).

Table 1.1. Southern Nevada population and land mass

Southern Nevada Population and Land Mass						
County	Population			Land Mass		
	2010 Total Population	60 and over population	Percentage of total population 60+	Square miles	Percent of state	Population per sq. mile
Frontier Counties						
Esmeralda	783	304	38.8	3,589	3.27	0.22
Lincoln	5.345	1,332	24.9	10,634	9.68	0.50
Mineral	4,772	1,514	31.7	3,756	3.42	1.27
Nye	43,946	14,019	31.9	18,147	16.52	2.42
White Pine	10,030	2,117	21.1	8,876	8.08	1.13
Urban Counties						
Clark	1,951,269	323,405	16.6	7,910	7.20	246.67

Table adapted from Nevada Aging and Disability Services Division (2012).

Nevada is one of the most geographically under-populated states, with a population so concentrated, as to make it also one of the most urbanized (Nevada Aging and Disability Services Division, 2012). In counties such as Esmeralda, Nye, Mineral, Lincoln, and White Pine, the federal government holds between 97 and 99 percent of land ownership in public lands, national forests, park lands, military installations, and other research facilities. This leaves about 14 percent of the state for private ownership or state and local control.

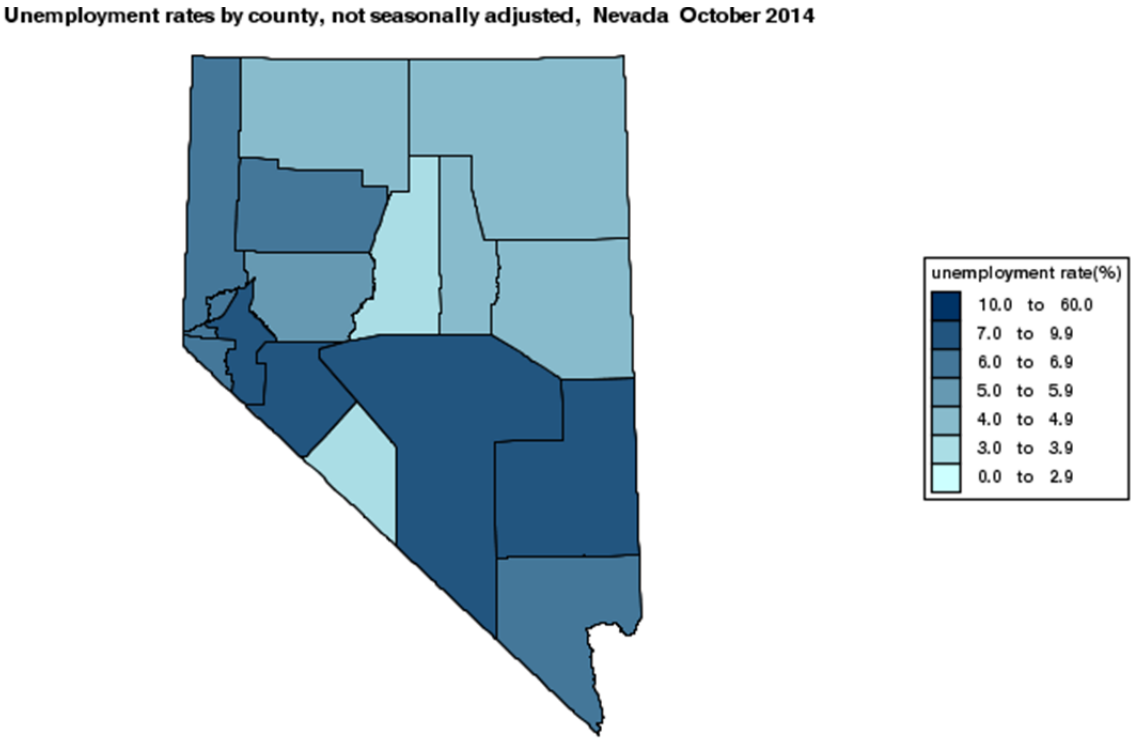
The great disparities in Nevada's population distribution have to do with geography and climate. Population centers are located near aquifers or major highways, thus leaving an average of 100 miles between major rural towns and only one interstate highway, I-15, passing through Southern Nevada and a second one, I-80, passing through the northern half of the state (Figure 1.3) (Nevada Aging and Disability Services Division, 2012). Furthermore, Nevada has 314 mountain ranges (NV Geodetic Survey, 2011) which make transportation between communities much more difficult. Nevada's diverse landscape and climate make for unpredictable weather patterns. Nevada's highest temperature was registered at 125º Fahrenheit in Laughlin (Clark County) in June 29, 1994. Cold temperatures in higher altitudes contrast with the hot desert weather. The state is also ranked one of the

http://geology.com/cities-map/nevada.shtml

Figure 1.3. Map of Nevada cities, towns and highways courtesy of

driest in the nation, with only an average annual rainfall of seven inches and only 0.6 percent of its land surface covered with water (Nevada Geography, 2011). Strong winds in Southern Nevada can cause severe sandstorms, as well as sudden heavy rainfall resulting in flash flooding. Such strenuous conditions throughout the state deter individuals from moving away from urban centers.

Clark County contains five cities: Boulder City, Henderson, Las Vegas, Mesquite, and North Las Vegas and a number of unincorporated towns (State Demographer, 2015). Clark is the most populous county in Nevada, containing 72.3 percent of the state's population (US Census, 2010).The census bureau estimates that in 2013, 2,027,868 persons lived in Clark County. Clark County is racially diverse: 72.7 percent of the population identified as White, but only 46.1 percent identified as Non-Hispanic/Latino. An estimated 11.5 percent identified as Black/African-American, 1.2 percent identified as American Indian and Alaskan Native (AIAN), 10.4 percent identified as Asian and Pacific Islander (API), 4.2 percent identified as two or more races, and 30.0 percent of respondents identified as being of Hispanic/Latino descent (US Census Quick Facts, 2013 data estimates). As of 2013, 21.8 percent of the population in Clark County was foreign born and 33.4 percent spoke a language other than English in the home. As of October 2014, the unemployment percentage in Clark County was 6.8 percent, according to the Bureau of Labor Statistics (2014) (Figure 1.4 for unemployment percentages by counties in Nevada), in comparison to the national rate of 5.8 percent. Higher education attainment is at 22.1 percent, below the national average of 28.8 percent, according to the Census Bureau Quick Facts estimates of 2009-2013. Median household income in Clark County is $52,827 for the years 2009-2013, slightly below the national average of $53,046 (US Census Quick Facts, 2013 data estimates).



http://data.bls.gov/map/MapToolServlet

Figure 1.4. Unemployment percentages by county

Esmeralda County has two unincorporated towns, Goldfield and Silver Peak (State Demographer, 2015). As of 2010, Esmeralda County had a population of 783 (US Census, 2010). Esmeralda's population is quite homogeneous with an estimated 89.3 percent of the population who claimed to be White alone and 82.1 percent identified as White alone of non-Hispanic/Latino descent. This means that, even though an individual is White, they can also be Hispanic/Latino, so by being White of Non-Hispanic/Latino descent, individuals self-identify as being of European heritage. Far above the state average of 1.6 percent, 5.0 percent of the population self-identified as American Indian or Alaska Native. (US Census Bureau Quick Facts, 2013 data estimates). Approximately 13.1 percent of the population in Esmeralda County is foreign born, in comparison to the State of Nevada, where 19.1 percent of the population is foreign born. Moreover, 15.3 percent of the population in Esmeralda speaks a language other than English in the home, half as much as the state average (29.3 percent) (US Census Bureau Quick Facts, 2013 data estimates). Esmeralda county had the lowest unemployment percentage in Southern Nevada as of October 2014 (3.2 percent), which was also roughly two and a half percentile points below the national average (Bureau of Labor Statistics, 2014). Only 13.9 percent of Esmeralda county residents obtained a higher education degree, well below the state rate of 22.4 percent. Median household income is also below the state median at $30,284, as opposed to Nevada's median household income of $52,800 for the period 2009-2013 (US Census Bureau Quick Facts, 2013 data estimates).

Lincoln County has one city, Caliente, and three unincorporated towns, Alamo, Pioche and Panaca (State Demographer, 2015). The population of Lincoln County is 5,345 people (US Census, 2010). This county has a homogeneous population, 91.9 percent of Lincoln County's population claimed to be White alone and 85.4 percent was White alone of non-Hispanic/Latino descent. Three percent of the population is foreign born and only 2.9 percent speak a language other than English in the home (US Census Bureau Quick Facts, 2013 data estimates). As of October 2014, the unemployment percentage in Lincoln County was 7.8 percent (Bureau of Labor Statistics, 2014). The percentage of population who has obtained a higher education degree is 16.3 percent and median household income for 2009-2013 is $40,143, about $12,000 below the state median (US Census Bureau Quick Facts, 2013 data estimates).

Mineral County has four unincorporated towns, Hawthorne, Luning, Mina and Walker Lake (State Demographer, 2015). With a population of 4,772 (US Census, 2010), Mineral County has an extremely high percentage of AIANs, comprising 16.5 percent of the population, far above the state average (1.6 percent). About 72.2 percent of the population claimed to be White alone and 65.9 percent self-identified as White alone of non-Hispanic/Latino descent. An estimated 4.7 percent of the population is foreign born and eight percent speak a language other than English in the home (US Census Bureau Quick Facts, 2013 data estimates). The unemployment percentage in Mineral County as of October 2014 was about three percentile points above the state rate at 9.7 percent (Bureau of Labor Statistics, 2014). About 11 percent of the population attained a higher education degree, far below the state average (22.4 percent). Median household income for the period 2009-2013 is $35,017, which is below the state average by about $17,000 (US Census Bureau Quick Facts, 2013 data estimates).

Nye County has seven unincorporated towns with the largest being Pahrump at a population of about 37,000. The second largest town is Tonopah with a population of about 2,600. The remaining towns in this county have populations of about a thousand or less (State Demographer, 2015). The largest land mass county in Nevada, with an area of 18,147 sq.

miles, Nye is sparsely populated with 2.42 persons per sq. mile (Nevada Aging and Disability Services Division, 2012). Nye county has a population of 43,946 (US Census, 2010). A homogeneous population, 90.1 percent of the population in Nye County claimed to be White alone and 77.7 percent are White alone of Non-Hispanic/Latino descent. Further, only 8.0 percent of the population is foreign born and 11.3 percent speak a language other than English in the home (US Census Bureau Quick Facts, 2013 data estimates). The unemployment percentage in Nye County was 7.8 percent as of October 2014 (Bureau of Labor Statistics, 2014). Higher education attainment is lower than the state average, only 12.3 percent of adults in Nye County have attained a higher education degree. The median household income between 2009 and 2013 is $39,876, which is also below the state average by about $13,000 (US Census Bureau Quick Facts, 2013 data estimates).

White Pine County contains the city of Ely and three unincorporated towns, Lund, McGill and Ruth (State Demographer, 2015). This county has a population of 10,030 individuals (US Census, 2010). About 87.2 percent of the population identified as White alone and 73.9 percent as White alone of Non-Hispanic/Latino descent. Moreover, 2.4 percent of the population is foreign born and 5.9 percent speak a language other than English in the home (US Census Bureau Quick Facts, 2013 data estimates). The unemployment percentage in White Pine County was 4.8 percent as of October 2014, below the state average rate (Bureau of Labor Statistics, 2014). As for higher education attainment, 13.8 percent of the population obtained a bachelor's degree or higher. Median household income between 2009 and 2013 is $48,586, slightly below the state's median (US Census Bureau Quick Facts, 2013 data estimates).

Purpose of the Community Profile Report

Susan G. Komen was founded on a promise between two sisters to save lives and end breast cancer forever by empowering people, ensuring quality care for all and energizing science to find the cures. The Community Profile is a snapshot of the community, specifically looking at breast health. Komen Southern Nevada uses the information obtained in the Community Profile to guide the work needed at the local level to meet this promise. Local experts were consulted to assure accurate information and stay involved every step of the way.

The information in this Community Profile will serve as an assessment of the local breast health community and will guide the following Affiliate activities:

- Drive inclusion efforts in the Southern Nevada breast health community
- Set granting priorities
- Advise on educational needs
- Strengthen message to the community and sponsors
- Establish methods of outreach in target communities
- Drive public policy efforts
- Serve as a tool for the Board of Directors and staff, community members, grantees, partners, sponsors and policymakers

In short, the Community Profile provides an up-close look at the unique characteristics of the Southern Nevada community. By observing the local needs, gaps and disparities, the community can be better served. Komen Southern Nevada will make the Community Profile available to the public through its website. A press release will be launched upon publication of

the Community Profile Report. Community partners, and especially grantees, are encouraged to read the community profile and utilize it as a tool in their evidence-based activities. Moreover, grant applicants must base their applications on the Community Profile, thus encouraging more organizations to read it as well.

Quantitative Data: Measuring Breast Cancer Impact in Local Communities

Quantitative Data Report

Introduction

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

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

The following is a summary of Komen® Southern Nevada'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

		Incidence Rates and Trends			Death Rates and Trends			Late-stage Rates and Trends		
Population Group	**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*	-
Nevada	1,300,998	1,487	111.8	1.5%	306	23.0	-1.5%	527	39.5	2.3%
Komen Southern Nevada Service Area	970,178	1,063	110.2	0.7%	223	23.3	NA	378	38.9	1.6%
White	740,680	873	113.6	1.1%	183	23.6	NA	307	39.9	2.4%
Black/African-American	112,609	94	105.4	3.3%	24	27.0	NA	41	43.0	0.3%
American Indian/Alaska Native (AIAN)	13,463	SN	SN	SN	SN	SN	SN	SN	SN	SN
Asian Pacific Islander (API)	103,426	72	71.0	0.4%	16	15.5	NA	25	24.3	-3.0%
Non-Hispanic/ Latina	707,434	938	113.5	1.3%	211	25.1	NA	329	40.1	2.6%
Hispanic/ Latina	262,744	125	88.1	-2.5%	12	10.3	NA	48	31.5	-7.0%
Clark County - NV	939,093	1,020	110.8	0.8%	213	23.3	-1.5%	362	38.9	1.6%
Esmeralda County - NV	372	SN	SN	SN	SN	SN	SN	SN	SN	SN
Lincoln County - NV	2,356	3	99.3	-24.6%	SN	SN	SN	SN	SN	SN
Mineral County - NV	2,444	SN	SN	SN	SN	SN	SN	SN	SN	SN
Nye County - NV	21,675	30	98.7	5.6%	8	24.4	NA	12	41.3	2.7%
White Pine County - NV	4,239	7	122.7	-2.7%	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 2005-2009 for incidence and late-stage data and 2006-2010 death data.
Rates are in cases or deaths per 100,000.
Age-adjusted rates are adjusted to the 2000 US standard population.
Source of incidence and late-stage data: North American Association of Central Cancer Registries (NAACCR) – Cancer in North America (CINA) Deluxe Analytic File.
Source of death rate data: Centers for Disease Control and Prevention (CDC) – National Center for Health Statistics (NCHS) death data in SEER*Stat.
Source of death trend data: National Cancer Institute (NCI)/CDC State Cancer Profiles.

Incidence rates and trends summary

Overall, the breast cancer incidence rate in the Komen Southern Nevada service area was lower 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 Nevada.

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 and lower among APIs than Whites. There were not enough data available within the Affiliate service area to report on AIANs so comparisons cannot be made for this racial group. The incidence rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

None of the counties in the Affiliate service area had substantially different incidence rates than the Affiliate service area as a whole or did not have enough data available.

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

Death rates and trends summary

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

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 and lower among APIs than Whites. There were not enough data available within the Affiliate service area to report on AIANs so comparisons cannot be made for this racial group. The death rate among Hispanics/Latinas was lower than among Non-Hispanics/Latinas.

None of the counties in the Affiliate service area had substantially different death rates than the Affiliate service area as a whole or did not have enough data available.

Late-stage incidence rates and trends summary

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

For the United States, late-stage incidence rates in Blacks/African-Americans are higher than among Whites. Hispanics/Latinas tend to be diagnosed with late-stage breast cancers more often than Whites. For the Affiliate service area as a whole, the late-stage incidence rate was slightly higher among Blacks/African-Americans than Whites 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 or did not have enough data available.

Mammography Screening

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

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

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

*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%
Nevada	1,716	1,229	73.1%	70.3%-75.8%
Komen Southern Nevada Service Area	655	486	75.2%	70.8%-79.1%
White	532	398	76.3%	71.6%-80.4%
Black/African-American	51	41	75.7%	59.4%-86.9%
AIAN	SN	SN	SN	SN
API	22	14	66.6%	42.3%-84.5%
Hispanic/ Latina	56	41	74.7%	59.2%-85.7%
Non-Hispanic/ Latina	599	445	75.3%	70.8%-79.3%
Clark County - NV	571	428	75.3%	70.7%-79.4%
Esmeralda County - NV	SN	SN	SN	SN
Lincoln County - NV	SN	SN	SN	SN
Mineral County - NV	SN	SN	SN	SN
Nye County - NV	84	58	72.3%	59.9%-82.1%
White Pine County - NV	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 Southern Nevada service area was not significantly different than that observed in the US as a whole. The screening proportion of the Affiliate service area was not significantly different than the State of Nevada.

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 and not significantly different 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 screening proportion among Hispanics/Latinas was not significantly different than among Non-Hispanics/Latinas.

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

Population Characteristics

The report includes basic information about the women in each area (demographic measures) and about factors like education, income and unemployment (socioeconomic measures) in the areas where they live (Tables 2.4 and 2.5). Demographic and socioeconomic data can be used to identify which groups of women are most in need of help and to 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 %
Nevada	78.6 %	9.6 %	1.9 %	10.0 %	73.4 %	26.6 %	46.2 %	32.4 %	13.3 %
Komen Southern Nevada Service Area	75.1 %	12.0 %	1.5 %	11.5 %	71.3 %	28.7 %	45.1 %	31.3 %	12.9 %
Clark County - NV	74.6 %	12.3 %	1.4 %	11.8 %	70.8 %	29.2 %	44.7 %	30.8 %	12.5 %
Esmeralda County - NV	93.5 %	1.2 %	5.3 %	0.0 %	84.7 %	15.3 %	64.9 %	54.3 %	26.0 %
Lincoln County - NV	95.5 %	1.4 %	1.7 %	1.4 %	94.7 %	5.3 %	54.2 %	42.1 %	19.8 %
Mineral County - NV	74.3 %	5.2 %	18.4 %	2.1 %	89.3 %	10.7 %	61.3 %	49.0 %	22.9 %
Nye County - NV	92.1 %	2.7 %	2.3 %	2.9 %	86.6 %	13.4 %	61.7 %	49.2 %	24.2 %
White Pine County - NV	91.5 %	1.4 %	5.5 %	1.6 %	88.0 %	12.0 %	52.5 %	39.7 %	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	Linguistic-ally Isolated	In Rural Areas	In Medically Under-served Areas	No Health Insurance (Age: 40-64)
US	14.6 %	14.3 %	33.3 %	8.7 %	12.8 %	4.7 %	19.3 %	23.3 %	16.6 %
Nevada	15.8 %	12.9 %	34.7 %	10.4 %	19.2 %	6.7 %	5.8 %	3.0 %	21.1 %
Komen Southern Nevada Service Area	16.6 %	13.1 %	36.0 %	10.6 %	21.5 %	7.8 %	2.7 %	0.7 %	21.5 %
Clark County - NV	16.5 %	12.9 %	35.9 %	10.5 %	21.9 %	8.0 %	1.3 %	0.5 %	21.5 %
Esmeralda County - NV	19.5 %	21.5 %	40.3 %	6.8 %	13.9 %	3.5 %	100.0 %	100.0 %	29.7 %
Lincoln County - NV	14.4 %	13.1 %	35.1 %	8.6 %	2.6 %	0.0 %	100.0 %	100.0 %	21.5 %
Mineral County - NV	14.0 %	21.9 %	36.5 %	9.1 %	4.1 %	1.5 %	31.9 %	0.0 %	21.5 %
Nye County - NV	19.4 %	20.5 %	42.0 %	15.6 %	8.5 %	2.5 %	35.3 %	0.0 %	21.5 %
White Pine County - NV	14.7 %	12.5 %	30.3 %	8.4 %	2.3 %	0.6 %	53.3 %	0.0 %	17.1 %

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

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

- Esmeralda County
- Mineral County
- White Pine County

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

- Esmeralda County
- Lincoln County
- Mineral County
- Nye County

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

- Nye County

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

- Nye County

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

- Esmeralda 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: 41.0 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 Southern Nevada 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 Southern Nevada 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
Nye County - NV	Highest	NA	13 years or longer	Older, poverty, employment, rural
Clark County - NV	High	9 years	13 years or longer	
Esmeralda County - NV	Undetermined	SN	SN	%AIAN, older, rural, insurance, medically underserved
Lincoln County - NV	Undetermined	SN	SN	Older, rural, medically underserved
Mineral County - NV	Undetermined	SN	SN	%AIAN, older, rural
White Pine County - NV	Undetermined	SN	SN	%AIAN, rural

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.

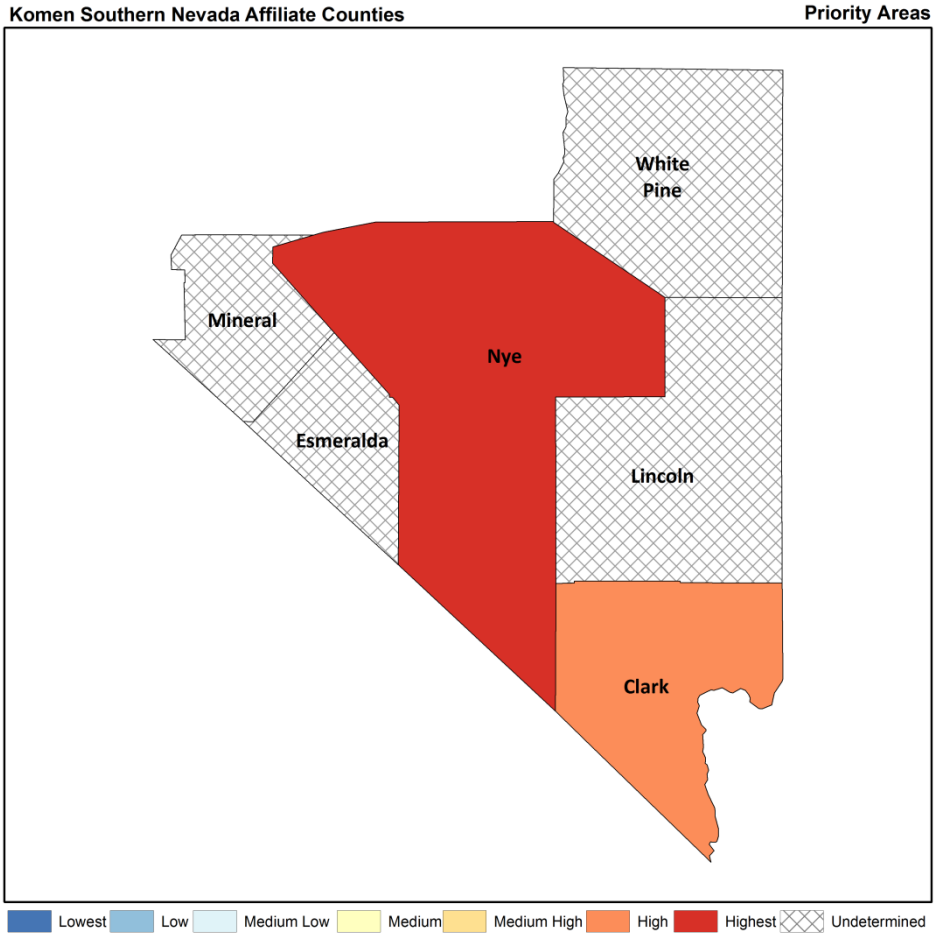


Figure 2.1. Intervention priorities

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

One county in the Komen Southern Nevada service area is in the highest priority category. Nye County is not likely to meet the late-stage incidence rate HP2020 target.

Nye County has an older population, high poverty levels and high unemployment.

High priority areas

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

<u>Selection of Target Communities</u>

The Affiliate has chosen three target communities within the service area. The Affiliate will focus strategic efforts on these target communities over the course of the next five years.
Target communities are those communities which have cumulative key indicators showing an increased chance of vulnerable populations likely at risk for experiencing gaps in breast health services and/or barriers in access to care.

When selecting target communities, the Affiliate reviewed Healthy People 2020, a major federal government initiative that provides specific health objectives for communities and the country as a whole. Specific to Komen Southern Nevada's work, goals around reducing women's death rate from breast cancer and reducing the number of breast cancers found at a late-stage were

analyzed. Through this review, areas of priority were identified based on the time needed to meet Healthy People 2020 targets for breast cancer.

Additional key indicators the Affiliate reviewed when selecting target counties included, but were not limited to:

- Incidence rates and trends
- Death rates and trends
- Late-stage rates and trends
- Below average screening percentages
- Residents living below poverty level
- Residents living without health insurance
- Unemployment percentages
- Residents who are linguistically isolated and/or foreign born

The selected target communities are:

- Clark County, Nevada (Las Vegas Ward 3, and Ward 5)
- Clark County, Nevada (North Las Vegas)
- Nye County, Nevada

Clark County

Clark County is the 12th largest county in the United States, covering an area the size of the State of New Jersey. With over 2 million residents and 70.0 percent of the state's population, Clark County consists of five cities: Las Vegas, Henderson, North Las Vegas, Boulder City and Mesquite. On an annual basis average, 1,487 new cases on breast cancer cases were observed in the State of Nevada between 2005 and 2009, with 1,020 of the cases occurring in Clark County. Clark County is expected to meet the Healthy People 2020 breast cancer death rate target in part due to a decreasing annual trend of -1.5 percent, but likely to miss the Healthy People 2020 late-stage incidence rate target in part due to an increasing annual trend of 1.6 percent (Table 2.1). While Clark County's screening mammography percentage (75.3 percent) is higher than the State of Nevada (73.1 percent), this percentage is lower than the US (77.5 percent). Clark County is also home to the service areas largest Black/African-American (12.3 percent), Asian and Pacific Islander (11.8 percent) and Hispanic/Latina (29.2 percent) female populations (Table 2.4). In addition, 21.9 percent of the county residents are foreign born and 8.0 percent are identified as linguistically isolated (Table 2.5).

The City of Las Vegas – the most populous in both the county and state – is divided into six wards. Wards 3 and 5 were selected as target communities because these counties are considered very low-income areas that experience some of the worst rates of disease, unemployment and health insurance participation. Poverty, poor education and high unemployment have been linked to breast cancer disparities in all areas of care, from screening to diagnosis (Susan G. Komen, 2014). In addition, language and cultural barriers may prevent some women from getting screened, seeking out treatment in a timely manner or receiving the standard of care when seen by a doctor (Susan G. Komen, 2014).

Las Vegas Ward 3

In Ward 3, the median age is 35.2 and 61.5 percent of residents are between the ages of 18 to 64 (Richard Wassmuth, 2012). According to US Census Bureau statistics published in 2012, the racial distribution of Las Vegas Ward 3 is 20.4 percent White and 63.0 percent Hispanic/Latino.

Blacks/African-Americans and Asians make-up 9.7 and 4.4 percent, respectively (Wassmuth, 2012). Hispanics make up 31.3 percent of City of Las Vegas residents as a whole, but Ward 3 is home to the largest population of Hispanics/Latinos out of the 6 Las Vegas Wards, with 38.2 percent of residents speaking a language other than English (Wassmuth, 2012). The median household income in Ward 3 is $34,161, compared to the median income in the City of Las Vegas, which is $54,174 (Wassmuth, 2012). Further, Ward 3 has the highest percentage of individuals living below the poverty level at 27.4 percent and the highest unemployment level at 15.5 percent (Wassmuth, 2012). It is important to note, in relation to Ward 3's population of Hispanics/Latinos, that Nevada has the highest proportion of undocumented residents in the country (Cancer in Nevada, Pinheiro PS, Reid S, Saccucci C, Harris D, Guinano M, 2012).

Las Vegas Ward 5

In Ward 5, City of Las Vegas Department of Planning reveals that the area is 30.5 percent is White, 39.5 percent Hispanic/Latino and 20.7 percent Black/African-American (Richard Wassmuth, 2012). Approximately 62.7 percent of Ward 5 residents are between the ages of 18 and 64 years (Wassmuth, 2012). Regarding employment, 66.6 percent of Ward 5 residents are in the labor force when looking at a population beginning at 16 years of age and 24.4 percent of individuals live below poverty level (Wassmuth, 2012). Approximately 38.2 percent of Ward 5 residents speak a language other than English (Wassmuth, 2012).

North Las Vegas

The City of North Las Vegas, in Clark County, Nevada was selected as a target community because of the percentage of residents that are foreign born, linguistically isolated and living below the federal poverty level. According to United States Census Bureau data, North Las Vegas, Nevada is racially diverse; Whites make up 47.4 percent, Hispanics/Latinos make up 38.8 percent and Blacks/African-Americans account for nearly 20.0 percent (2008-2012). More than one in five North Las Vegas residents are foreign born and 40.0 percent speak a language other than English in the home (US Census Bureau, 2008-2012). Additionally, more than 15.0 percent of North Las Vegas residents are living below the federal poverty level (US Census Bureau, 2008-2012). The current unemployment rate in North Las Vegas is 15.62 percent, which is higher than in Las Vegas and Nevada as a whole (U.S. Bureau of Labor Statistics, State Unemployment Rates, 2014).

Nye County

Nye County, Nevada is the third largest county in the United States, covering 18,181 square miles with the six main communities being Amargosa Valley, Beatty, Gabbs, Pahrump, Round Mountain/Smokey Valley and Tonopah (Nye County Comprehensive Economic Development Strategy, 2013 Annual Update Report). However, despite the large size, the population in 2013 was estimated at 42,297, with Whites making up 92.1 percent of the population, followed by Hispanics/Latinos at 13.4 percent, Asian/Pacific Islanders at 2.9 percent, and Blacks/African-Americans at 2.7 percent (US Census Bureau, 2013 and Table 2.4). The median household income in Nye County is $39,150, with 20.5 percent of the population living below 100 percent poverty level, 15.6 percent unemployed and 35.3 percent of the individuals residing in designated rural areas (US Bureau of Labor Statistics, 2014 and Table 2.5). Although death rate trend data were not available for Nye County, the county's death rate (24.4 per 100,000) is higher than the State of Nevada (23.0) and US (22.6) (Table 2.1). With an increasing late-stage annual trend (2.7 percent), Nye County is likely to miss the HP2020 late-stage incidence rate target (Table 2.1).

In the health systems section of the profile, the Komen Southern Nevada Affiliate plans on delving deeper into the breast health care offered in the target communities and the access obstacles that exist to the population who reside within these target communities. This includes a focus on residents living without health insurance and the rate of care pursued in relation to the lack of insurance. For the public policy section of the profile, the Affiliate is going to look closely at the problems Southern Nevadans have experienced with signing up for Affordable Health Care through the Silver State Health Insurance Exchange. Additionally, the Affiliate will concentrate on the undocumented population and the Nevada Co-Op Health Insurance, which offers health insurance to this population. Finally, the Affiliate will closely examine Women's Health Connection, which is Nevada's version of the NBCCEDP, and the challenges the program faces on a regular basis.

Health Systems Analysis Data Sources

The following sources have been used to construct the Health System Analysis and the Public Policy sections of this report:

- Mammography Centers: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfMQSA/mqsa.cfm
- Hospitals: https://data.medicare.gov/Hospital-Compare/Hospital-General-Information/v287-28n3
- Local Health Departments: http://www.naccho.org/about/lhd/
- Community Health Centers: http://findahealthcenter.hrsa.gov/Search_HCC.aspx
- Free Clinics: http://www.nafcclinics.org/clinics/search
- American College of Surgeons Commission on Cancer: http://datalinks.facs.org/cpm/CPMApprovedHospitals_Search.htm
- American College of Radiology Centers of Excellence: http://www.acr.org/Quality-Safety/Accreditation/Accredited-Facility-Search
- American College of Surgeons National Accreditation Program for Breast Centers (NAPBC): http://napbc-breast.org/resources/find.html
- National Cancer Institute Designated Cancer Centers: http://www.cancer.gov/researchandfunding/extramural/cancercenters/find-a-cancer-center
- Google was also used to identify health care facilities in the target communities

Additionally, websites with information about the Affordable Care Act were consulted. A list is presented below:

- Nevada Health Link 2014 Enrollment Information: https://www.nevadahealthlink.com/Content/pdf/2014EnrollmentInformation.pdf
- Nevada Health link: https://www.nevadahealthlink.com/
- Silver State Health Insurance Exchange: Fiscal and Operational Report of December 2013

The Community Profile Team collected data from the aforementioned sources to determine all the services along the Continuum of Care provided in the target communities. Things the Team looked for were: facilities where any sort of screening was carried out (i.e. clinical breast exams, mammograms or patient navigation), facilities where there was a diagnostics department for breast cancer, treatment facilities and survivorship support services (i.e. financial aid, legal aid, support groups, counseling, etc.). Furthermore, a series of key informant interviews were done where the Team sought information about the Affordable Care Act. Seven key informant interviews were carried out. Key informant interviewees were comprised of two patient navigators, two health department workers, two ombudsmen at the Governor's Consumer Health Advocate Office and a breast care nurse. Additionally, the Affiliate receives a large number of phone calls and personal visits of individuals asking for assistance. A written log of such interactions is kept. The Mission Manager looked through the log of the last twelve months in order to understand the greater need in the community in terms of breast care services.

Some limitations that were considered in the process of compiling and analyzing the data were as follows:

- Although an effort was made to remove any bias from key informants by rephrasing questions, it is extremely difficult to separate the opinion of interviewees from their responses.
- The Community Profile Team researched online sources for services in the target area and they also considered existing resources through previous partnerships and relationships with grantees. However, it is extremely difficult to account for all services in the target community since some organizations may be smaller or they may not be listed online.
- Although phone calls and personal visits from individuals seeking resources in the community are a good indicator of what services may be missing, only those women who are ready to ask for help are represented in this sample. This is a convenience sample and may not represent the needs of the population as a whole.

Health Systems Overview

In order to understand the process a woman follows within a health system for her breast care a model, which is called the Continuum of Care (CoC) (Figure 2), is used. 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 3 to 6 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 ~~follow up~~ appointments and understanding what it all means. Education can empower a woman and help manage anxiety and fear.

If breast cancer is diagnosed, she would proceed to treatment. Education can cover such topics as treatment options, how a pathology 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 efficiently.

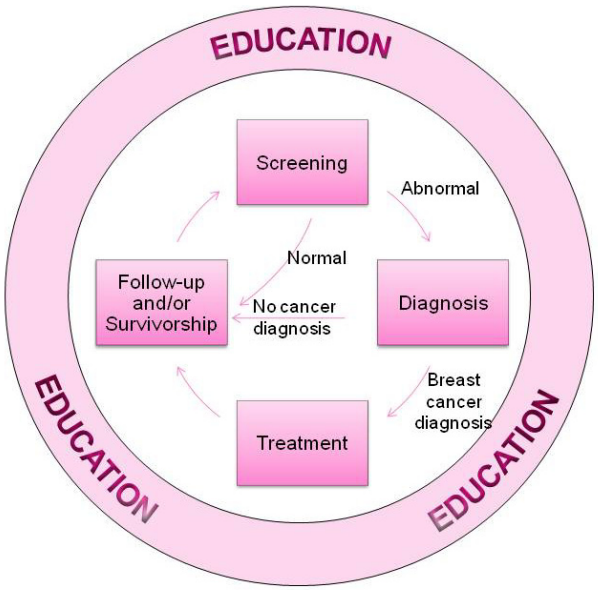


Figure 3.1. Breast Cancer Continuum of Care (CoC)

Each target community has a number of screening facilities that offer clinical breast exams (CBEs), especially North Las Vegas, Las Vegas Ward 3 and Ward 5 in Clark County. These three communities have an assortment of facilities that offer clinical breast exams and patient navigation. However, mammograms in these communities are harder to come by, especially for uninsured or underinsured individuals who cannot afford to pay for a mammogram out of pocket. North Las Vegas only has two medical facilities that offer mammograms and one of them is a VA hospital; therefore, it is not open to the general public (Figure 3.2). Las Vegas Ward 3 has two facilities that offer mammograms and Las Vegas Ward 5 has no health care facilities where mammograms are offered (Figures 3.3 and 3.4). There are even fewer diagnostic facilities in these communities and no treatment options are available. Unless patients have insurance, they are sent somewhere else in the Las Vegas Valley for follow-up diagnostic tests. Only three locations offer cancer treatment in Las Vegas and none of them are in these two wards or in North Las Vegas.

The county hospital (University Medical Center), which was the main provider of cancer treatment for the uninsured and underinsured, has shut down its oncology department as of August 2014. This means that there will be an overflow of patients in need of chemotherapy and other treatments. For those who have health insurance, they may simply transfer to other facilities in the city. However, the bigger problem revolves around those patients that do not have medical insurance; they may be denied treatment at other facilities or, if they are given treatment, they may not be able to make payments up front as is expected of them. Furthermore, survivor services are practically nonexistent in the target communities and individuals have to travel to different places across the city in order to access them.

Nye County is extremely rural and sparsely populated. With the majority of the population concentrated in Pahrump and Tonopah, all health centers that provide breast health screening services, except for one, are situated in these two urban centers (Figure 3.5). Furthermore, the majority of community clinics are staffed with nurses only; therefore, the CoC ends at screening in these communities, where only a clinical breast exam is offered. There are two health care facilities that offer mammograms. However, if there are any abnormalities, patients are sent elsewhere for follow-up and diagnosis. Health departments in Tonopah and Pahrump offer financial assistance for individuals who may need to travel somewhere for further tests or treatment. All in all, individuals in this county have to travel long distances even to get screened, which may hinder women from entering the continuum of care.

Nevada Health Centers offers the Mammovan, a mobile mammography unit that travels throughout the State of Nevada, including all of the target communities. This van offers mammograms to both insured and uninsured women. However, because there is only one Mammovan travelling throughout all of Nevada, visits are few and far between within the target communities.

Because Clark County is very culturally diverse, not every patient receives treatment that is adequate to their culture. Even if a translator is present in the room or the medical provider speaks the primary language of the patient, there is still a cultural disconnect. Therefore, many individuals in minority groups choose not to receive medical treatment unless it is extremely necessary. In other words, preventive screenings are overlooked and deemed unimportant by these groups for two main reasons: 1) Patients feel like they aren't being heard by their medical provider or they do not understand their medical provider, and 2) there is an overall lack of knowledge of how to navigate the health care system. For the undocumented population, this becomes even more of a problem because they also fear being reported to Homeland Security.

Komen Southern Nevada is a member of the Nevada Cancer Coalition (NCC), which works to implement and update the Nevada Comprehensive Cancer Control Plan by looking at five specific categories: prevention, early detection and diagnosis, treatment, clinical trials and quality of life and palliative care. Additionally, the Affiliate staff and Board members are members of the Las Vegas Metro Chamber of Commerce and the Boulder City Chamber of Commerce. These memberships allow the Affiliate to share the Susan G. Komen® promise with community members and engage in collaborative opportunities. Komen Southern Nevada also attends various functions with the Urban, Latin, Asian and North Las Vegas Chambers of Commerce.

Moreover, the Affiliate has a long history of collaboration with various businesses and nonprofit organizations that provide breast cancer screening, education and outreach, treatment and support services for the uninsured and underinsured. Although these organizations serve the target communities, most of them are located outside the target communities, which means that individuals who seek their services have to travel longer distances. A list of the organizations the Affiliate is working with is provided below:

Screening services
St. Rose Dominican Hospitals' R.E.D. Rose Program, Women's Health Connection, Nevada Health Centers, Inc. Mammovan, Planned Parenthood and Southern Nevada Health District.

Treatment services
As of November 2014, the Affiliate does not have any partnerships with organizations that provide treatment services.

Support services
O'Callaghan Resource Integrated Oncology Network (ORION) Cancer Foundation, Barbara Greenspun WomensCare Center of Excellence, The Caring Place, The Breast Center at Sunrise, Young Survival Coalition, American Cancer Society, Center for Compassionate Care, Carol's Post Mastectomy Specialists, Wigs on the Move, Mobile Medical Services, Nevada 211, The R.E.D. Rose Program, Office of the Governor Consumer Health Assistance, Nevada Tobacco User's Helpline and HELP of Southern Nevada.

Education services
Sisters Network, Community Partners for Better Health, Witness Project, UNLV's Center for Health Disparities Research and National Cancer Institute's Cancer Information Services.
The Affiliate is hoping to strengthen its relationship with the Office of the Governor Consumer Health Assistance so that there is a flow of individuals between the two entities in order to ensure that all of their needs are met in as few steps as possible.

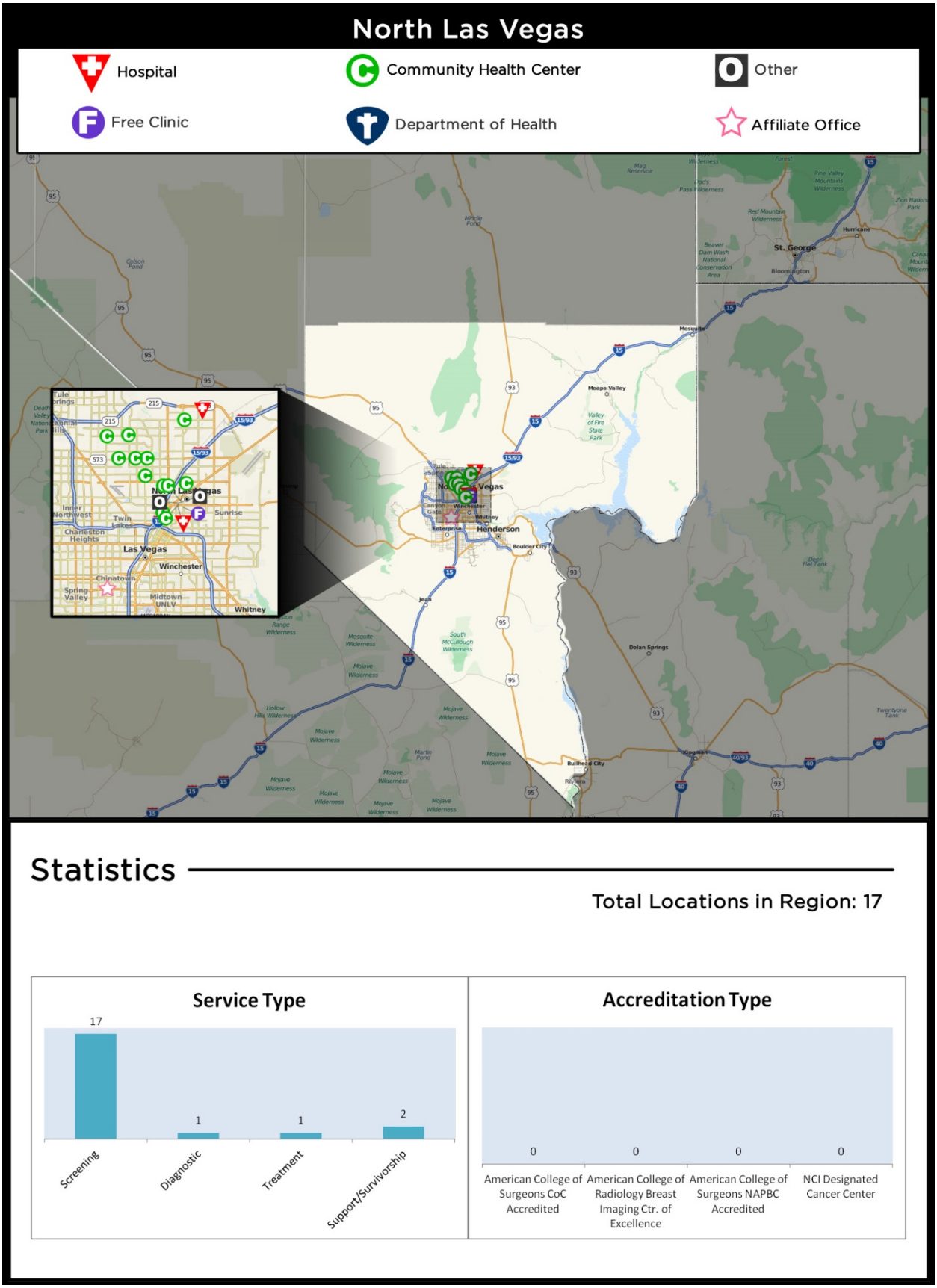


Figure 3.2. Breast cancer services available in North Las Vegas

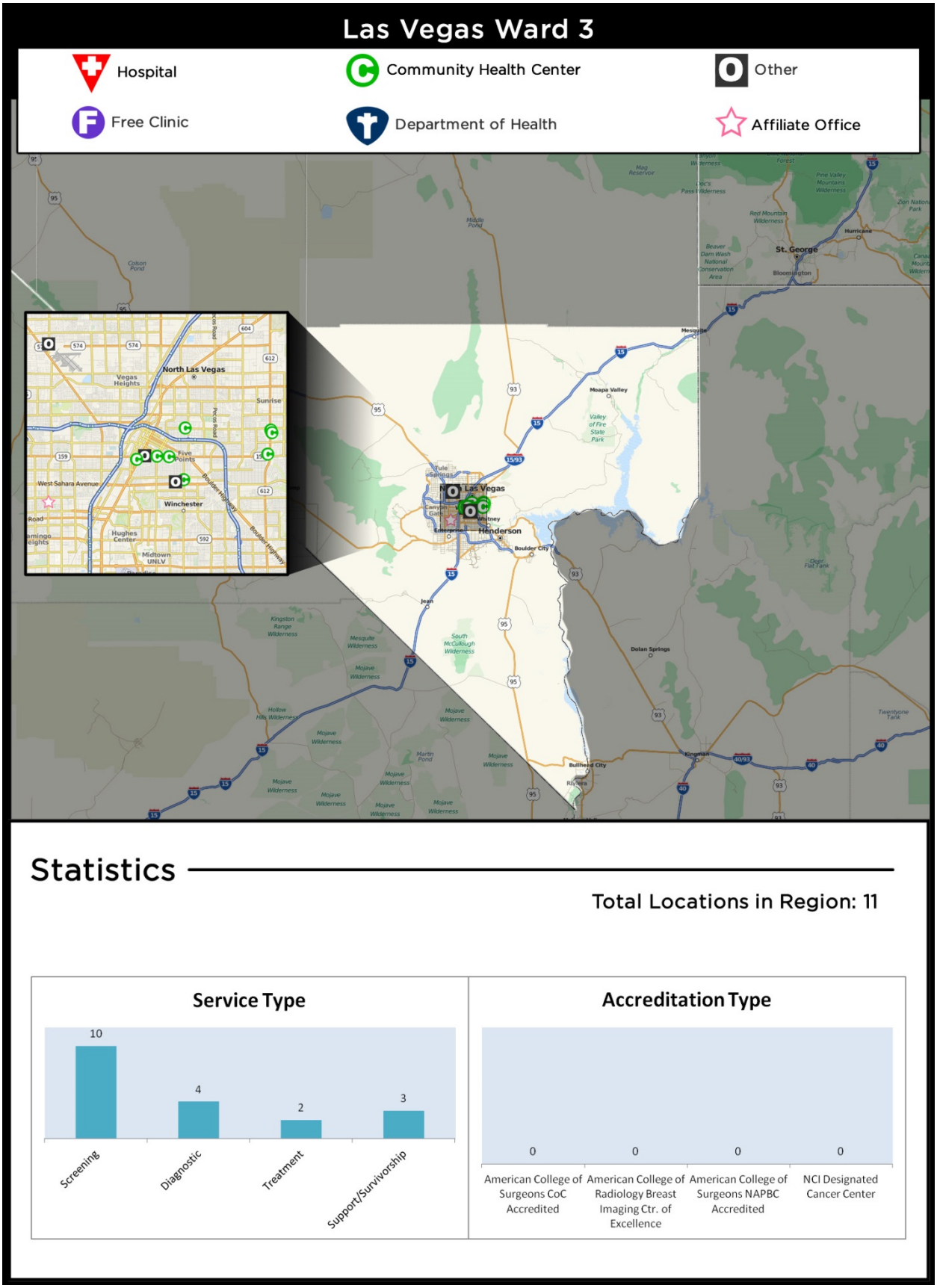


Figure 3.3. Breast cancer services available in Las Vegas Ward 3

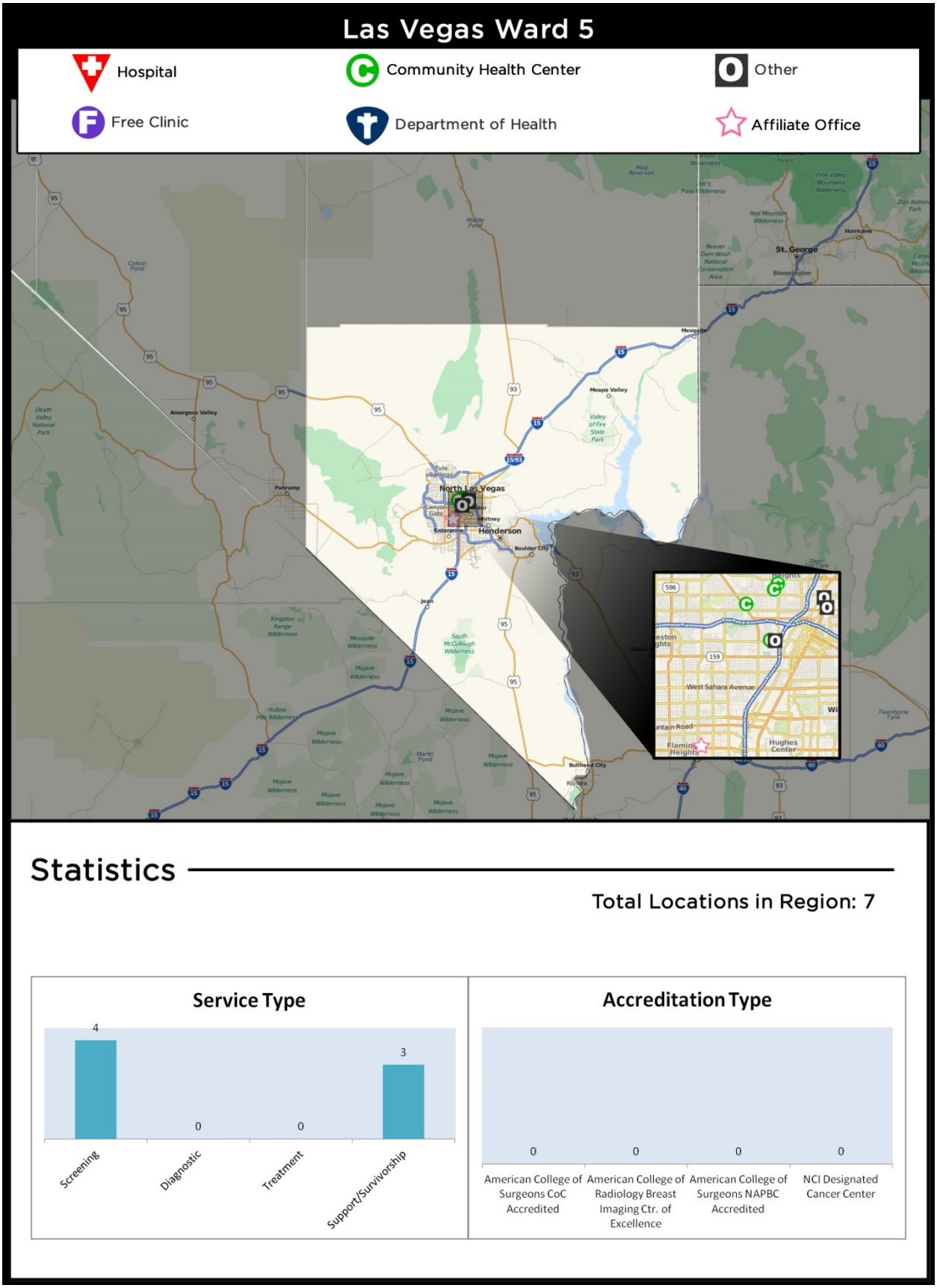


Figure 3.4. Breast cancer services available in Las Vegas Ward 5

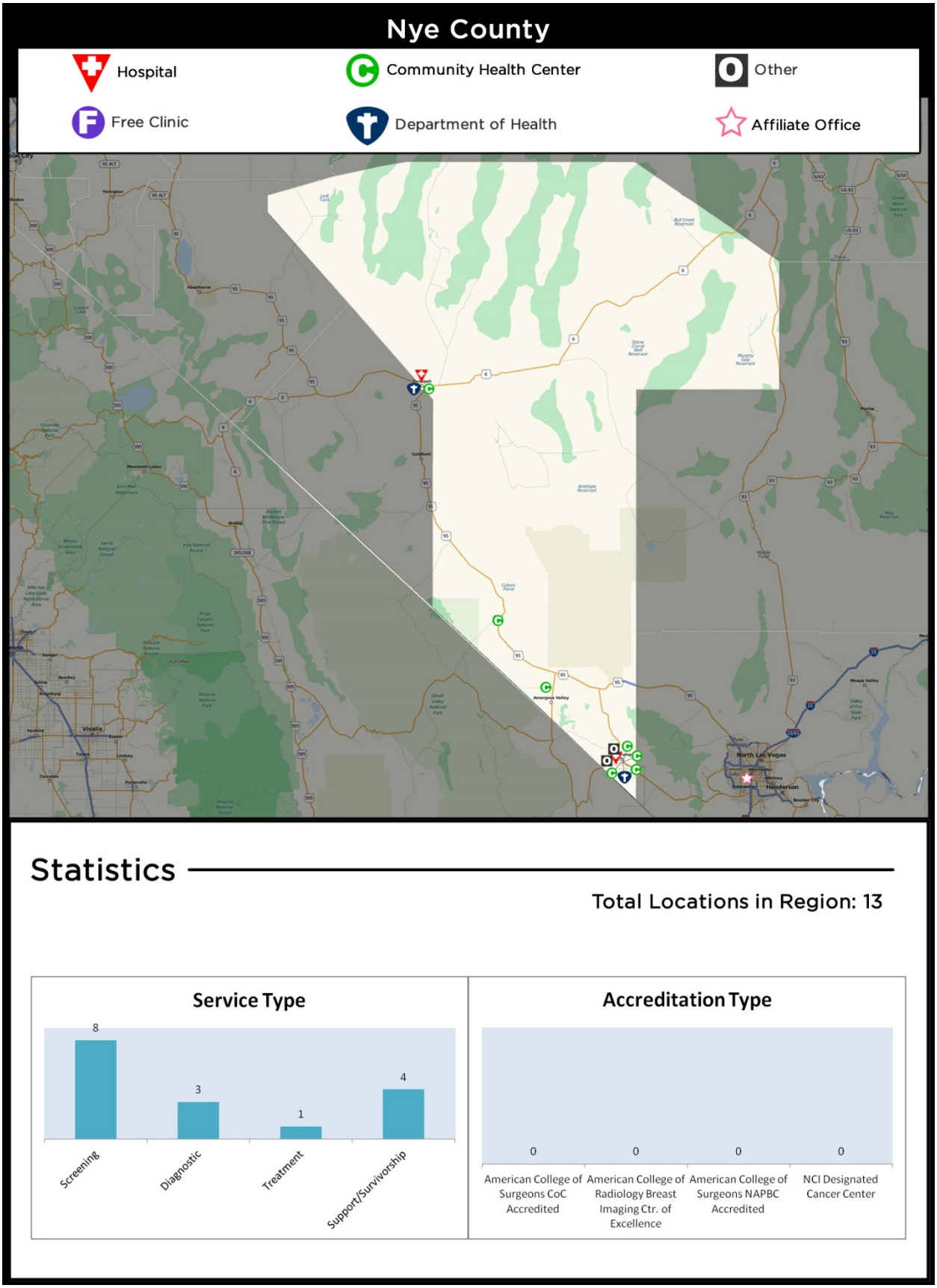


Figure 3.5. Breast cancer services available in Nye County

Public Policy Overview

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

Since 1997, the National Breast and Cervical Cancer Early Detection Program (BCCEDP) has provided funding to the Nevada Division of Public and Behavioral Health to provide services through Women's Health Connection (WHC). WHC is 100 percent CDC funded for an average of $2.4 million per year, providing screening and diagnostic services to an average of 600 women a month in the entire State of Nevada. Sixty percent of these funds must be used for direct clinical services and the remaining 40 percent may be allocated to support infrastructure functions. Beginning in July 2011, the Nevada Division of Public and Behavioral Health created a sub-grant with Access to Healthcare Network (AHN) to manage WHC. AHN, a previous Komen Southern Nevada grantee through the Patient Care Fund, provides breast and cervical cancer screening services to women who are 40 years of age and older, uninsured or underinsured, annual income is 250 percent of the Federal Poverty Level (FPL) or less and not eligible for Medicare Part B. Although this program serves as the foundation to the network of breast health services throughout Southern Nevada, it has several limitations including a lack of funding (from state and federal governments), restrictive eligibility criteria for screening and a loophole for diagnosed women seeking treatment. If a woman is diagnosed outside of a WHC-approved facility, she is not eligible for treatment under WHC.

Because of lack of funding, AHN has age restrictions that prevent some women from receiving their recommended breast cancer screenings. WHC follows US Preventive Services Task Force (USPSTF) Guidelines for screening for breast and cervical cancer. The program pays for an annual pelvic exam, a pap test and an annual clinical breast exam. This is done for women ages 40-49. A mammogram will only be covered if a woman presents with unusual symptoms during her clinical exam. However, various other sources have different screening recommendations for mammography beginning at age 40 (American Cancer Society, 2008; Susan G. Komen, 2014). In addition to the services listed above, women ages 50 and older will also receive a mammogram during their yearly exam. Currently, in 2014, Komen Southern Nevada funds a grant that provides mammograms to women that do not qualify for Women's Health Connection. Nevada is one of the states with the most restrictive coverage options through the Breast and Cervical Cancer Prevention and Treatment Act. Women who are diagnosed with breast or cervical cancer will have full access to Medicaid only if, 1) they were screened at an AHN-approved facility and, 2) they meet all additional requirements to enroll with Medicaid. To qualify for Medicaid coverage under the program, women must be under the age of 65, not previously eligible to receive Medicaid, meet citizenship requirements and be without credible health care coverage. These women are only eligible for Medicaid coverage while they are undergoing cancer treatment. This is not a sustainable option because, once the treatment is over, their coverage is over and does not take into account survivorship treatment of any sort. However, women who would otherwise be eligible to receive Medicaid-funded treatment are not allowed to receive it based on where they were screened. So, if a woman is diagnosed at a non-AHN provider clinic, she is ineligible for Medicaid treatment coverage.

State Comprehensive Cancer Control Coalition

Nevada's Comprehensive Cancer Coalition is a nonprofit collaboration between state and local governments, health, medical and business leaders, the research community, cancer survivors, caregivers and advocates. Nevada's Comprehensive Cancer Plan has five fundamental goals:

- Reduce the risk for developing cancer
- Increase early detection and appropriate screening for cancer
- Increase access to appropriate and effective cancer treatment and care
- Address quality of life issues for health care consumers affected by cancer
- Improve the coordination and collaboration between cancer control efforts

Komen Southern Nevada is a member of the Nevada Comprehensive Cancer Control Coalition. Although the Nevada Comprehensive Cancer Coalition is very active in Northern Nevada, it is not as active in the Southern part of the state. The Affiliate is part of a steering committee trying to increase the Coalition's presence in Southern Nevada in order to improve comprehensive cancer services in the community. It is the hope of the Affiliate that in the next four years the steering committee will have achieved a more united comprehensive front for cancer care.

Affordable Care Act (ACA)

Nevada has opted for expansion of Medicaid for individuals up to 138 percent of Federal Poverty Level (FPL). This means that a large number of individuals who were not covered by Medicaid before are now covered. Furthermore, Nevada has created a state-based marketplace for eligible individuals to purchase health care. Any individuals who have an income between 139-400 percent FPL are eligible for the program. The Silver State Health Insurance Exchange, or the Nevada Health Link, is the online resource where individuals can go to register for insurance under the ACA.

According to the Census Bureau's March Supplement to the Current Population Survey (the CPS Annual Social and Economic Supplement or ASEC, 2014) by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute in the year 2012-2013, 27.0 percent of the non-elderly population was uninsured (20.0 percent of children ages 0-18 and 29.0 percent of adults ages 19-64). The estimated uninsured population after the ACA implementation and Medicaid expansion is 19.6 percent according to the Kaiser Foundation (2014) - an estimated decrease of 6 percent of the uninsured. However these numbers vary depending on the source. The Silver State Health Insurance Exchange Fiscal and Operational Report of December 2013 estimates that two thirds of individuals who were uninsured in 2011 will be eligible for Medicaid and the remaining one third will be eligible for the Nevada Health Link, thus leaving no uninsured individuals in the state. However, being eligible for a certain medical insurance plan does not mean automatic enrollment. A big problem in Southern Nevada is the undocumented population, who are not eligible for Medicaid or allowed to purchase insurance through the Nevada Health Link. Most health insurance companies, with the exception of a handful such as Nevada Cooperative, do not accept applications where the beneficiary does not have a Social Security Number. Therefore, all undocumented immigrants, which Clark County has the largest undocumented population in the country, will remain uninsured or underinsured.

The large influx of patients that were previously uninsured has offered its own set of challenges within the health care system. Some of these challenges include:

- Educating and enrolling the insurance eligible population
- Expanding Medicaid Services to absorb the Medicaid expansion
- Increased provider demand and, in some areas, provider shortages

Enrollment periods for Nevada Health Link are limited to a few months each year. The enrollment period in 2014 ended on March 31 and it will start again on November 15 for the

2015 enrollment period. This left many individuals unenrolled during the first enrollment period, either because they did not know about the program or because they thought it was not an important expense. During the off season only those who have a Qualifying Life Event (QLE) or are eligible for Medicaid are allowed to enroll. An individual may be considered to have a QLE if:

- There is a Marriage, Birth or Adoption of a Child, Divorce, Move to a New Service Area or Loss of Other Coverage, among others
- There was an exceptional circumstance or other complex personal situation that prevented the individual from applying or enrolling by the end of the Open Enrollment Period (i.e. serious medical condition or natural disaster)
- Individuals who are members of federally recognized American Indian or Alaskan Native tribes

Before the ACA was implemented, 2013 regulation stipulated that, in order to qualify for Medicaid in Nevada, unemployed individuals with children had to have annual incomes at 24.0 percent or less of FPL and, if employed, their income could not be more than 84.0 percent of FPL. With the expansion of Medicaid in Nevada, anyone who has an income of 138 percent FPL or lower qualifies for Medicaid. Those women with an income between 139 percent and 250 percent FPL are eligible for AHN, and, in particular, the WHC program. Preliminary data estimated that about 45 percent of WHC clients are eligible for Medicaid and about 5 percent of WHC clients are eligible for the Nevada Exchange, according to enrollment information. Those women who are eligible for AHN are assisted through the navigation process and fast tracked for Medicaid services if cancer is diagnosed. However, all those individuals who are now eligible for Medicaid that were not before are left to navigate the system on their own. This causes a problem in that individuals who were not a part of the health care system previously do not necessarily know what to do when faced with a medical problem.

Although Medicaid expansion lowers the patient load in AHN, in theory, numbers are still high. In fact, WHC has not seen a decrease in their screening services during 2014. Because Nevada Health Link has a limited enrollment season, individuals who might qualify for ACA, who did not enroll during the allotted season, fall through the cracks. There are also those patients who cannot enroll with Nevada Health Link because 1) they cannot afford it, 2) they choose to pay the fine, or 3) they are in the country illegally. Most of these individuals will still be eligible for WHC and take advantage of the services.

WHC has tried to smooth the transition of its clients over to ACA plans (Medicaid or Exchange) in the following ways:

1. Sent over 9,400 postcards to their clients informing them of the Exchange and Medicaid during 2013
2. Working with Medicaid to link program data. This will assist the transition of those individuals who enrolled in Medicaid and facilitate their termination process with WHC
3. Updating their “Welcome Package” to add ACA information and enrollment materials
4. Ensuring that providers scan individuals for ACA eligibility and assist them with the enrollment process
5. Ensuring partnerships between enrollment assisters, AHN and WHC to ensure eligible women are enrolled into Medicaid or Exchange
6. Conducting additional provider questionnaires to identify gaps/needs with regard to the enrollment process.

During the first enrollment period, the Nevada Health Link experienced a number of technical difficulties. For instance, individuals who were filling out a registration form weren't able to finish it and all their information was lost, inexplicable errors appeared in the system and there was no way to resolve them. In other cases, applications that had been completed did not go through the system so, although individuals thought they had health insurance, in reality they did not because their information had never reached health insurance companies (despite having paid all of their premiums). Technical assistance during the enrollment period and customer service could not meet all the requests that the aforementioned technical difficulties caused. In view of what happened during the previous open enrollment period it has been decided that going forward enrollment into Nevada Health Link will happen through healthcare.gov. However, Nevada is still considered to have its own marketplace. The US Department of Health and Human Services (HHS) will only be responsible for handling applications. Insurance premiums will be paid directly to the health insurance companies. The Silver State Marketplace will still be customized to Nevada.

Although health insurance is made available for more individuals, this does not mean automatic enrollment, as it has been demonstrated in 2014. Therefore, the Affiliate may still need to focus efforts in assisting the uninsured and underinsured. The Affiliate foresees a greater need for patient navigation, as individuals who did not have access to the health care system suddenly do, and do not necessarily know how to navigate it. The ACA does not look at survivorship support services and there is a lack of such services in the target communities. Therefore, Komen Southern Nevada will need to continue to encourage the presence of survivorship support services.

Affiliate Public Policy Activities

Komen Southern Nevada makes an effort to have a presence in public policy issues within the state that will affect mission work of the Affiliate. In 2009, Susan G. Komen Southern Nevada organized a Lobby Day, where elected officials were invited to the Affiliate office and participated in a round-table discussion about local breast health services, where the gaps occur and what programs were in place to alleviate some of the need. Komen Southern Nevada, along with Komen Northern Nevada, also coordinated gatherings during the past two state legislative sessions (2011 and 2013) for elected officials and their staff to discuss how Susan G. Komen has Nevada "covered in pink" with services reaching each corner of the state. Komen Southern Nevada hopes to continue its relationship with Nevada State legislators in the upcoming four years through the existing partnership with Komen Northern Nevada and the ties already formed in Southern Nevada.

Health Systems and Public Policy Analysis Findings

Southern Nevada, and, in particular, the target communities, have a good amount of screening facilities for younger women, where CBEs are offered. However, mammograms are harder to come by, especially for uninsured and underinsured women. In terms of diagnosis or treatment, women in target communities in Clark County have to travel to different parts of the Las Vegas area and women in Nye County have to travel an average of 250 miles to Las Vegas. Support services are seldom in the target communities, and, although they are available in Las Vegas, women must travel long distances to access them. Even if women live in the Las Vegas area, if they do not have access to a private vehicle, a 15 mile drive can easily become a three and a half hour journey each way by bus. Women in Nye County who need diagnostic tests or

treatment can apply for travel financial aid from the Nye County Health Department. The Nevada Health Center's Mammovan is a mobile mammography unit that travels through the state offering mammograms to uninsured or underinsured women. Often, the Mammovan is the only form of medical assistance that women see in months. Furthermore, there is a lack of culturally competent medical professionals, thus deterring ethnic minorities from seeking preventive health care services.

Komen Southern Nevada has strong partnerships with various organizations in the community throughout the CoC, except for treatment, because there were few treatment options in Southern Nevada target communities in 2014. Susan G. Komen of Southern Nevada hopes to strengthen its ties with governmental entities in order to facilitate the navigation of patients during diagnosis, treatment and survivorship.

Access to Healthcare Network is currently managing the Women's Health Connection (WHC) grant that provides screening and treatment services for uninsured women with funding from the Centers for Disease Control and Prevention (CDC). However, due to low funding and CDC restrictions, WHC does not reach as many women as needed. Although the ACA was thought as a great way to improve health coverage and screening percentages among women, results have not shown this to be the case. Enrollment rates were not as high as expected during the 2014 enrollment period. Furthermore, mismanagement of the Nevada Health Link resulted in tremendous frustration and individuals who thought they were insured were, in fact, not. Nevada expanded Medicaid to individuals up to 138 percent of FPL, however, again, enrollment was not as high as expected and there is a large need for patient navigation now as a lot of individuals who did not previously have access to the health care system are now enrolled and lack an understanding of how to use it.

Komen Southern Nevada has held a Lobby Day in the past where elected officials have been reminded of Susan G. Komen's mission to save lives and end breast cancer forever. More recently, Komen Southern Nevada and Komen Northern Nevada joined forces to remind the importance of breast cancer to the Governor through a letter campaign. The Affiliate is actively looking for ways to continue and expand its current public policy efforts.

Qualitative Data Sources and Methodology Overview

Methodology

Throughout the Quantitative Section and the Health Systems and Public Policy Analysis Section of this report, the Community Profile Team has compiled a series of questions to better understand what the community thinks and how these data make sense in everyday realities. During this section, the Team tried to answer the following questions:

1. Do individuals in the target communities have knowledge of breast health and risk reduction behaviors?
2. Does an individual's place of residence alter their understanding of breast health?
3. What are the main barriers stopping individuals in the target communities from accessing breast health care?
4. What are the best ways to reach individuals in the target communities?

In order to answer these questions, the Team utilized a series of data collection methods. To begin with, a short survey was distributed in both English and Spanish at four organizations where individuals from the target communities access services. The organizations distributing the survey were the Responsible Early Detection Rose (R.E.D. Rose) Program at St. Rose Dominican Hospitals, Barbara Greenspun WomensCare Center also at St. Rose Dominican Hospitals, Nevada Health Centers Mammovan and REACH/Ventanilla de Salud at the Mexican Consulate in Las Vegas. Through these four outlets, 223 surveys were collected. These organizations were selected because, even though the R.E.D. Rose Program and the Barbara Greenspun WomensCare Center are not located in the target communities, a large portion of clients in all four organizations live in the target communities. Distributing these short surveys during the clients' appointment made it so that individuals would be more inclined to participate in the study and, because of the length and simplicity of the questionnaire, subjects were not intimidated by it. Workers and volunteers in these facilities were trained on how to distribute the instrument so that the community assessment for the Community Profile created as little disruption to the organizations' typical services as possible. The Mission Manager entered the data collected through these surveys into a Microsoft Excel worksheet using a previously created codebook and, later, the software SPSS was used to perform statistical analysis of the data collected.

A series of key informant interviews were conducted where the Team sought information about the implications of the Affordable Care Act, barriers to health care and best practices. Eight key informant interviews were carried out. Key informant interviewees were comprised of three patient navigators, two health department workers, two ombudsmen at the Governor's Consumer Health Advocate Office and a breast care nurse. Interviews were recorded and transcribed by the Mission Manager. Subsequently, they were analyzed for common themes and ideas. Interviewees were asked the same question differently several times in order to avoid bias. However, it is impossible to separate an individual and their expertise from their opinions. Not all interviewees work in the target communities, however, due to the fact that many services are not available in the communities, interviewees do largely work with individuals from target communities.

The Team conducted two survivor focus groups where they discussed their experience with the health care system during their diagnosis and treatment, as well as their navigation of the CoC.

Topics such as challenges with health insurance or the emotional stress of deciding treatment options were discussed. Women were screened by the Mission Manager prior to participating in the focus group and also filled out a short demographic survey. Although most participants do not reside in the target communities, the Team decided that information gathered during these discussions was relevant to the overall study due to the fact that there are not many treatment options in Southern Nevada and, therefore, most women access the same facilities. Thus, some experiences between women in the target communities and these women are similar. However, the Team is aware of the fact that information gathered in these focus groups is not necessarily representative of the experience of survivors in the target communities. Women participating in the focus groups simply inform of the general experience of survivors with health insurance going through diagnosis and treatment in Southern Nevada.

Finally, the Community Profile Team conducted a document analysis. Google Scholar was used as the main search engine and the search terms were: 'Nye County, NV,' 'Nevada,' 'access to health care,' 'barriers to health care,' and 'health services.' Furthermore, any sources used in the list of articles generated by this search that seemed relevant to the subject were also tracked down. The Team also searched for all relevant Healthy People 2020 reports and Nye County Health Department reports. The Mission Manager read and analyzed all articles and reports in order to find relevant information to answer the questions in this section.

Although four different methods were used, they complement each other. Surveys help the Team understand what individuals in the community think, while key informant interviews express what health care professionals perceive and, finally, the literature gives an academic perspective to the issues under study. All these methods looked at access and barriers to health care, as well as the knowledge of individuals and how to better reach them. Focus groups, on the other hand, focused on survivors' experiences, thus resonating with the difficulties of navigating the continuum of care once it has been entered.

Sampling

223 surveys were distributed through the R.E.D. Rose Program, Barbara Greenspun WomensCare Center, Nevada Health Centers Mammovan, and REACH/Ventanilla de Salud. The only criteria in this sample were that subjects had to be women and they had to be at least 18 years old. 86 surveys were collected from North Las Vegas, 71 in Las Vegas Ward 3, 66 in Las Vegas Ward 5, and none in Nye County. Because REACH/Ventanilla de Salud operates out of the Mexican Consulate in Las Vegas, a large proportion of surveys were completed by Hispanics/Latinas, which is not a representation of the ethnic composition of the target communities. Similarly, for the two focus groups, the Team sent a request to the Affiliate's survivor database and the focus groups were formed based on the responses to the e-mail. These two focus groups were not specific to either target community, but rather to Southern Nevada at large. Because of the way services are distributed and the fluidity of Las Vegas and North Las Vegas, the Team decided that the data collected during these focus groups would be relevant to the Community Profile as a whole. Each focus group had five participants. Individuals who took part in the surveys or focus groups were asked to identify where they lived. Finally, for the interviews, the Community Profile Team identified eight individuals who might produce the most valuable information. North Las Vegas, Las Vegas Ward 3 and Las Vegas Ward 5 are extremely fluid, meaning that individuals travel between these and other areas of the city. Based on that, it was decided that key informant interviews did not have to take place in the target communities per se, so long as the interviewees worked in the target communities or with

individuals who resided in those communities. Six of the interviewees who were in Clark County confirmed that they work with individuals from both North Las Vegas and Las Vegas Ward 3 and Ward 5, thus, these interviews were used for these two target communities. The exception to this was, to some extent, Nye County. The Team sought two interviewees from this community; however, due to the smaller population and the lack of services, less data were obtained from that area. All data were collected through convenience samples.

Ethics

Individuals who took part in focus groups or key informant interviews were asked to sign an informed consent form, where the Community Profile was explained, as well as how their participation in the study was relevant and how it would be utilized. Subjects were also told that participation in the study was voluntary and that they could withdraw at any time with no consequences. Similarly, participants did not get a reward for taking part in the study. Survey participants were asked to give oral informed consent. The reason for doing this was because the survey was quite short, about a page, and they were given out during appointment time, in some cases, so the Team wanted to take as little time from both clients and organization workers as possible.

Surveys were completely anonymous. As for focus groups and key informant interviews, participants were given a code name at the time of transcription and, from that moment onward, their code name is how they were identified during the study. Additionally, participants were asked whether they could be quoted directly in the report or not and their wishes were respected. All recordings and transcripts of focus groups and interviews were stored in a Komen computer and will be erased after the Community Profile report is finished. An original copy of all completed surveys was stored in the Affiliate's office during the Community Profile writing process. Once the process is over, all surveys will be shredded in order to protect the anonymity of participants. Any literature used during this section was properly cited and sources were adequately acknowledged in this report.

Qualitative Data Overview

The Community Profile Team used several data collection methods. For each method used, the Team collected data in different formats. Surveys were used to gauge the community's understanding of screening services. In this case, data were collected in a short survey. This was a multiple-choice survey and, therefore, answers were easily coded for the subsequent statistical analysis. Data collection during key informant interviews took place in the form of interview notes and recordings (subsequently recordings were transcribed in the Affiliate's office), if interviewee agreed to being recorded. Data during the focus groups was recorded in the form of a verbatim transcript, which was then printed and themes were identified within the transcript. Finally, the Community Profile Team searched for documents in the form of reports and scholarly articles that were relevant to this section of the Community Profile. It was decided to utilize statistical analysis for the surveys because, since they were multiple-choice, it made more sense to understand what the majority of the population thinks. Additionally, by using this method, the Community Profile Team could find correlations between different answers more easily. A set of themes were identified prior to key informant interviews and focus groups. This was done in order to be able to answer the questions set forth at the beginning of this section. Interviewers took note of any answers related to the established themes and of any further themes that prevailed throughout the interview. Because there was a recording and transcript of

each key informant interview, the Team could go back to the recording and transcript for further mentions of the new theme. Similarly, the Team read through the transcripts of the focus groups in search of pre-established themes. However, again, if any other prevailing themes appeared throughout the transcript, the Team took note of them, too.

Themes and descriptives were chosen in two ways: 1) themes that were needed in order to answer the questions set forth at the beginning of this section and 2) themes that reappeared throughout the data collection process. Originally, the Team began with a large collection of themes, however, these were merged and, eventually, there were just a handful of themes, such as fear of the unknown, health professional's help, or lack, of knowledge. Based on these themes, the literature was read in an effort to find things that enhanced the information gathered through the data collected, or to provide further information from the communities where the Team had difficulty accessing said information.

North Las Vegas, Clark County

North Las Vegas is the most ethnically diverse city in Clark County (Susan G. Komen, 2014). The three main reasons women gave for not having had a previous mammogram, according to the surveys, were as follows: 1) they thought they were too young, 2) their doctor did not recommend it, and 3) they did not have health insurance (Figure 4.1). According to the surveys, about thirty percent of women who had a mammogram stated they had one because the doctor recommended it (Figure 4.2), thus emphasizing the importance of health care providers to improve screening outcomes.

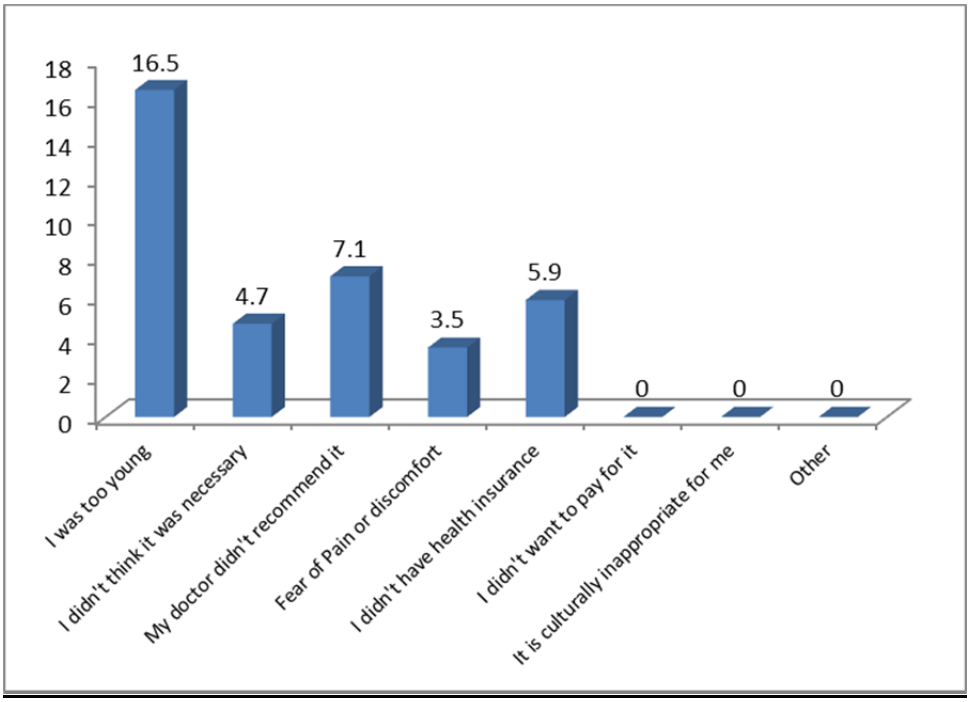


Figure 4.1. Reasons respondents did not have a previous mammogram- North Las Vegas

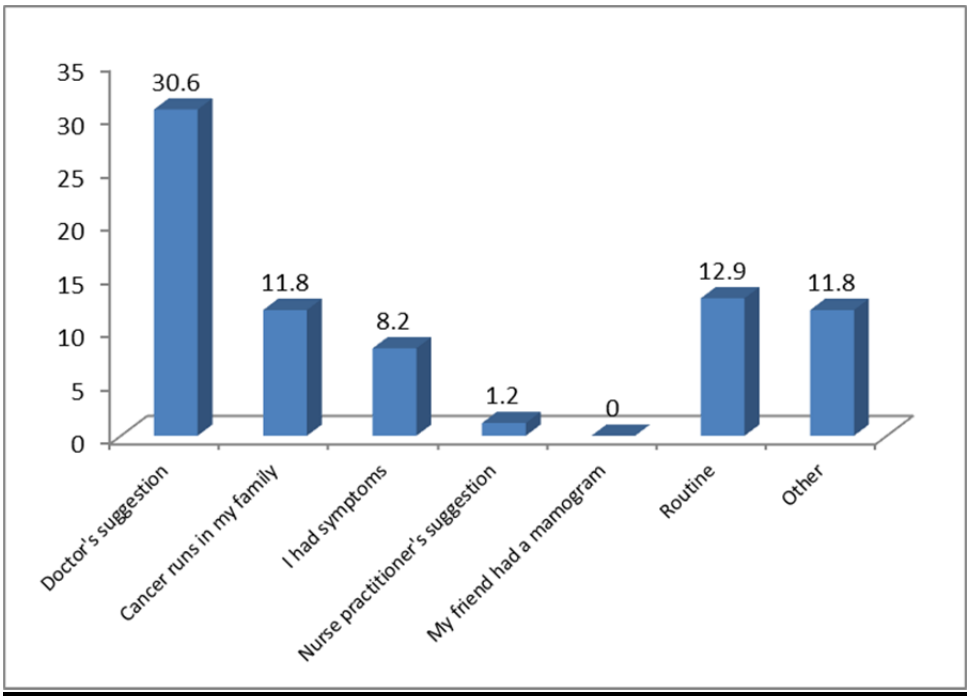


Figure 4.2. Reasons respondents did have a previous mammogram- North Las Vegas

Interviewees stated that one of the problems they saw in individuals in the target communities was that, due to the lack of health insurance, individuals did not access preventive services, such as wellness checkups or screening tests. Key informant interviewees were concerned about the use of health care services after the ACA. It was a theme in most interviews that, despite the fact that the ACA has improved access to health insurance, and, therefore, to health services, enrollment in an ACA plan or Medicaid is not accompanied by a training course on how to navigate the health care system. Often times, as was observed in the surveys, women wait to be told by their health care providers that they should get a mammogram. However, if they only go to see the doctor when there is something wrong, which is the case according to the interviews, they are less likely to be told of the need of a screening mammogram. The chart below (Figure 4.3) looks at the percentage of women who were age appropriate for a mammogram, knew the Komen guidelines and who did have a mammogram, according to data collected through surveys. Although North Las Vegas respondents had the highest percentage at just below 90 percent, it is not all women.

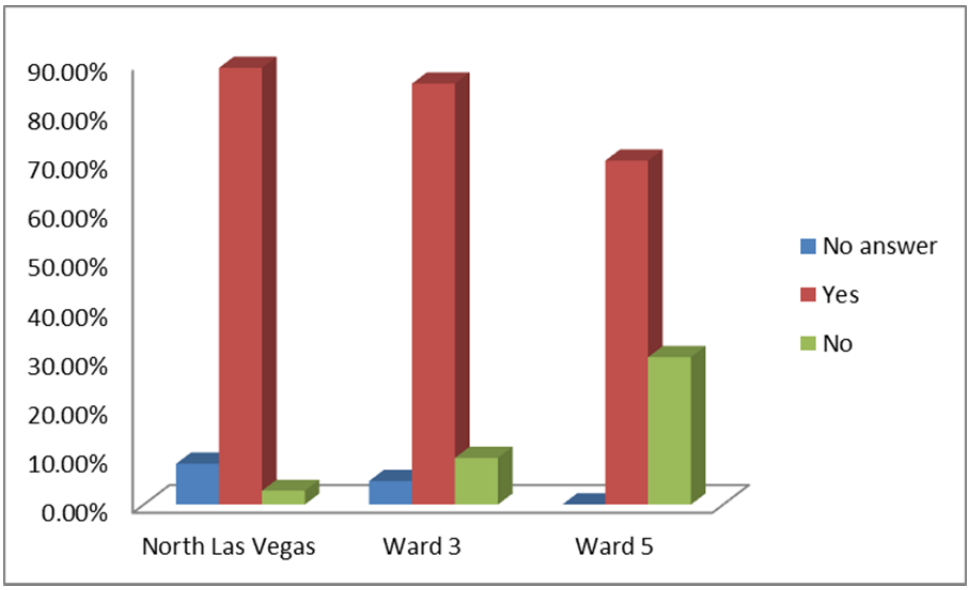


Figure 4.3. This chart represents the percentage of women who were age appropriate (40 years or older) who knew that, they had to have their yearly mammogram starting at age 40 and who actually had a mammogram.

One of the interviewees thought there should be training classes for individuals who are new to the health care system. In summary, she said that there were two main reasons for having workshops or classes on how to navigate the health care system: 1) individuals have never had access to the health care system and do not know how to navigate it and 2) undocumented individuals and legal immigrants are not only in a new culture and need to learn how to navigate a new health care system, but doctors are not culturally competent. Being culturally competent does not only mean speaking one's mother tongue, it also means understanding the different needs that a patient has depending on their country of origin. Such needs can vary from having a female health care provider to having breast cancer be a taboo that needs to be approached in a completely different way than it would with an American patient.

There are many perceptions as to why women in North Las Vegas do not get mammograms, however, the main reason, according to women who took the survey, is lack of health insurance (Figure 4.4). Figure 4.4 illustrates all the reasons that women perceived as reasons for not having mammograms in their communities (note that different circle sizes carry no meaning in Figure 4.4).

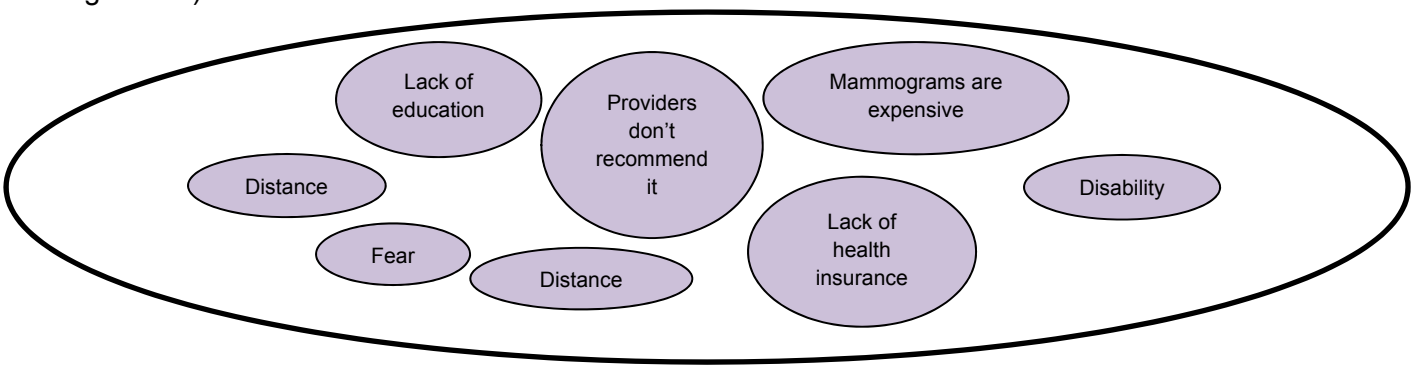


Figure 4.4. Perceptions in target communities for why women aren't getting mammograms, according to surveys.

Lack of education was also considered an important factor deterring women from accessing mammography as a screening test. When asked about ways in which women in the communities should be educated, the overwhelming majority of respondents emphasized the importance of both health care providers and health fairs as appropriate educational and informational outlets.

Las Vegas Ward 3 and Ward 5, Clark County

As in North Las Vegas, in these two Las Vegas Wards, surveys showed that women who did not have a previous mammogram did not do so, mainly because they thought they were too young. Lack of health insurance was the next barrier for women to access a screening mammogram (Table 4.1).

Table 4.1. Reasons why women did not get previous mammograms by percentage

Reasons for no previous mammograms	Ward 3	Ward 5
I was too young	25.7	22.7
I didn't think it was necessary	12.9	7.7
My doctor didn't recommend it	12.9	7.7
Fear of Pain or discomfort	4.3	3.1
I didn't have health insurance	17.1	16.9
Other	0	6.2

According to the surveys, about 24 percent of women in Ward 3 and about 27 percent of women in Ward 5 who had a mammogram in the past claimed to have had a mammogram because their doctor recommended it. The second main reason why women had screening mammograms in these communities was because they were symptomatic. Having a mammogram because a woman has symptoms emphasizes the idea that women, in this case, will only seek medical help if perceived necessary due to illness. In Ward 3 only about eight percent of women who had had a mammogram in the past did it as part of their medical checkup. In Ward 5, the percentage was even lower at 1.5 percent.

Much like in North Las Vegas, surveys showed that Las Vegas Wards 3 and 5 residents perceive that the main reason why women do not access screening mammograms is lack of health insurance, followed by the cost of mammograms and lack of education (Figures 4.5 and 4.6).

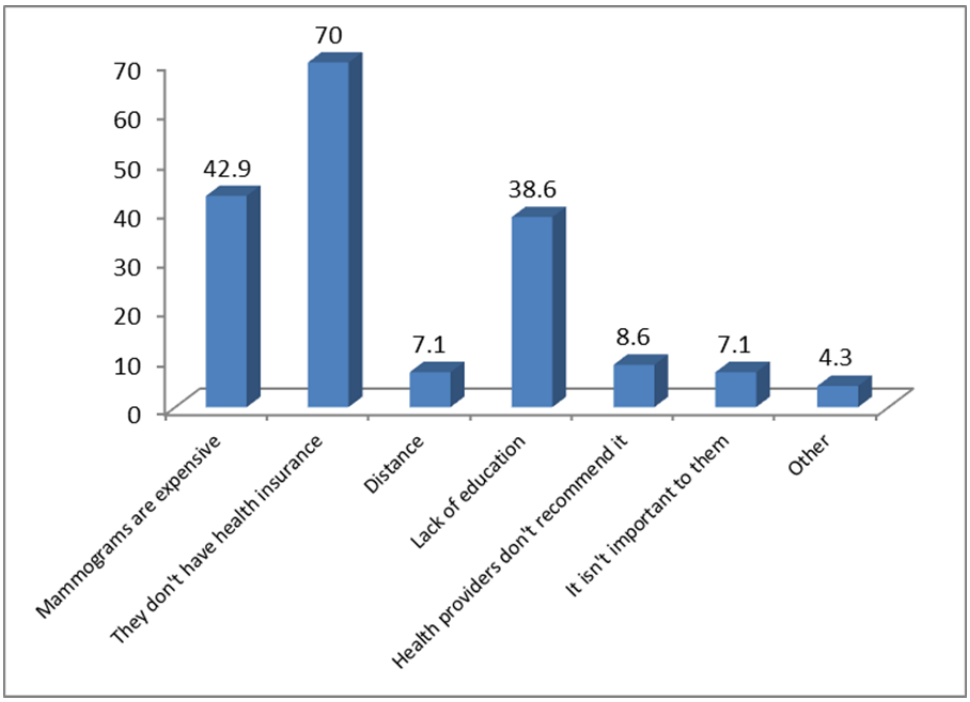


Figure 4.5. These charts represent the percentage of individuals who think women in their community do not have mammograms by reason- Las Vegas Ward 3

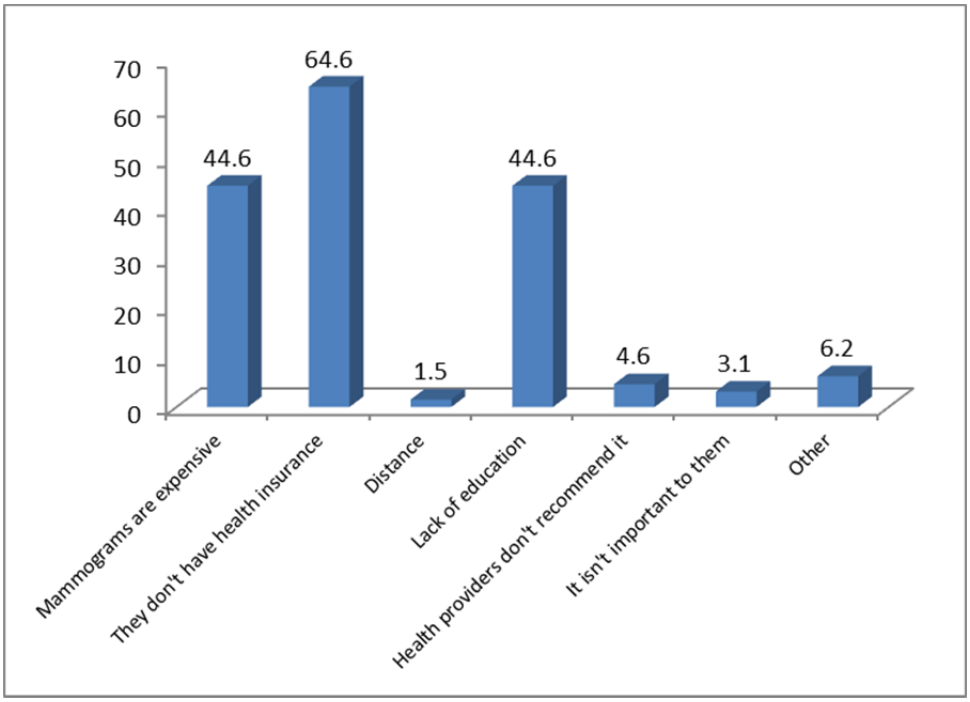


Figure 4.6. These charts represent the percentage of individuals who think women in their community do not have mammograms by reason- Las Vegas Ward 5

Many of the women who were surveyed expressed the need for more information. Despite having had mammograms, they did not fully understand why they needed to have them or how breast cancer could affect their lives. This sense of missing information was shared by survivors in focus groups, who claimed they felt the need to have had more information provided to them from the moment they had a suspicious mammogram. Focus group participants thought it would be important for health care providers to give more information and educational materials to

newly diagnosed patients right away. All survivors in the focus groups spoke highly of their breast care nurses and how much information they provided for them. However, survivors felt there was a long waiting period between the moment they were given a diagnosis and the moment they met with their breast care nurse. Similarly, some survivors showed concern about how little guidance they were given in ways to take care of themselves. For instance, a survivor told the story about how a newly diagnosed friend of hers took a shower with her drains on right after surgery and how she did not know how to apply the bandages. The lack of treatment facilities and the overflow of patients, according to key informant interviews, might be the reason for the difficulty accessing information, both before a woman enters the CoC, or even once she has entered it with a breast cancer diagnosis.

There are many ways to reach women so that they can, at the very least, enter the CoC. According to most key informant interviewees, there are screening resources available for the underinsured and uninsured in Southern Nevada, but there are few screening facilities in the target communities for the medically underserved. It was found that those who most need services do not normally know of all the available services. Furthermore, there is not much assistance for treatment if a cancer is diagnosed and the patient is an undocumented person, which is a concern for a number of interviewees. In order to educate their communities about the importance of mammography, survey participants in Ward 3 and Ward 5 thought that their health care providers should take up the role as main educators (Figure 4.7).

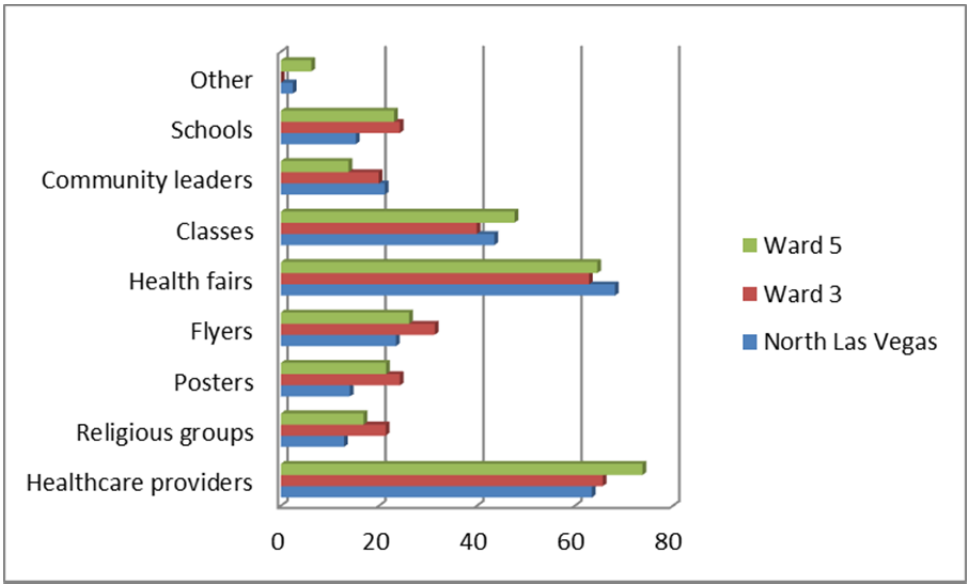


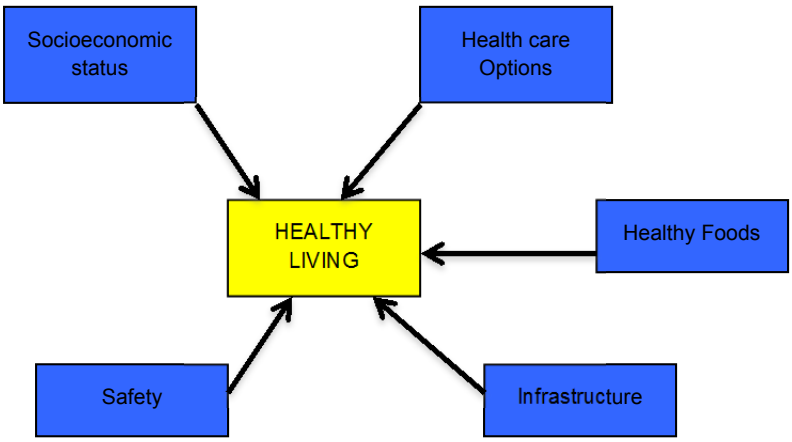
Figure 4.7. Survey respondents indicated what they thought were the best ways to educate their communities. This chart portrays the percentage of individuals that chose each answer.

According to the surveys, health fairs are popular among the target populations and they are a great first point of contact between those who need screenings and services. However, as key informant interviewees pointed out, a health fair setting offers limited educational potential, especially when it comes to discussing breast health issues. In some cultures, breasts are viewed as a taboo or simply as a feminine subject. Thus, key informant interviewees think that workshops and classes that are culturally appropriate inside the communities are the best way to educate individuals. Although health care professionals are viewed as a maximum authority to educate women about mammography, if these women only go to the doctor when there is an

emergency, chances are that mammography will not be discussed. Ultimately, key informant interviewees believe that workshops advertised at health fairs, community centers, schools, health clinics, etc. become a more viable option.

Nye County

Nye County has a large percentage of elderly population (Susan G. Komen, 2014: Keene et al., 2012). Although some of these individuals live with family or a significant other, unfortunately, the vast majority live alone. With one of the lowest life expectancies within the state (Washington Post, 2011), and a problem of outmigration of the younger populations, Nye County is faced with a deficit of services to cater to the needs of their population (Keene et al., 2012). There are many factors that contribute to healthy living within a society including social support, employment, education, accessibility to health care and fresh foods, among others (Figure 4.8). However, if infrastructure is not in place to allow for a healthy lifestyle, it will not happen (Monnat, 2012).



Adapted from Monnat, 2012.

Figure 4.8. Component of healthy living

Nye County scored as one of the bottom counties in the healthy society indicators due to their low Social and Economic Factors score, which placed them at the bottom of the scale. Additionally, Nye County has the highest unemployment percentage in the State of Nevada (Susan G. Komen, 2014). According to key informant interviewees, there are two main issues for women in Nye County accessing health care: 1) lack of insurance and lack of income, and 2) the need to travel long distances. According to the same interviewees, a lot of individuals in the county do not own a private vehicle and travel to Las Vegas for medical checkups and treatment becomes a hazardous and long journey due to the lack of public transportation and the long distances. Although they remain optimistic that the ACA will make it so that more individuals can access affordable health care, this still remains to be seen.

Studies in rural regions of the United States show that mammography screening percentages among rural women are lower than among their urban counterparts (Edwards and Tudiver, 2008) and so, ultimately, diagnosis occurs at a later stage (Amey, Miller and Albrecht, 1997). As key informant interviewees explained, and the literature confirms, this is due to the lack of insurance, education, economic means, or poor accessibility of mammography screening services (Lipsky et al. 2008). Key informant interviewees in Nye County praised the service that

the Nevada Health Centers Mammovan (a mobile mammography unit) offers to their harder to reach communities. However, they were concerned about the scarcity of visits. Nye County has one major urban center, Pahrump (State Demographer, 2015), therefore, key informant interviewees were concerned about the difficulty to reach individuals who live in the most rural areas of the county. Primary health care providers have a pivotal role in breast cancer screening and diagnosis (Rayman and Edwards, 2010). The literature shows that primary care providers in rural areas value their relationships and the rapport they built with their patients and they consider it especially important to treat a patient's illness holistically (Rayman and Edwards, 2010). Such trust relationships have proven to be successful in efficient treatment of a patient's health (Parchman and Burge, 2004). However, interviews revealed that the problem for many individuals in Nye County is entering the CoC.

Studies show that the majority of cancer patients living in rural areas think that travel for treatment is a major source of stress and worry, especially if they are responsible for taking care of other family members or the family business (Butow et al. 2012). Furthermore, those individuals who can stay at home during treatment appreciate the sense of normality that comes with it (Schlegel et al. 2009). However, patients who stay away from home feel as though they have stronger social support due to the interaction they have with other individuals going through the same situation (Payne et al. 2001). Another need linked to travel for treatment in rural communities, according to other studies, is the lack of information prior and during the trip in terms of health information, support services, etc. (Davis et al. 2003; Wilkes et al. 2006; Fitch et al. 2003).

Qualitative Data Findings

While the short surveys were a good and efficient way to capture what individuals in target communities think, they were collected through a convenience sample, thus creating an unrepresentative sample of the target communities. Additionally, since approximately half the surveys were collected inside the Mexican Consulate, it created an overrepresentation of Hispanics/Latinas. Furthermore, because these surveys were distributed at health programs, it is to be assumed that women answering them were not only more predisposed to take care of their health, but also to want to look like they were healthier than they might really be. In order to avoid some of the bias, ethnicity was not taken into consideration when examining these surveys. Although most questions in the survey were multiple-choice, there was always the option "other" with space to write one's thoughts. The Team thought that adding the possibility of "other" allowed for no limitations in the respondents thoughts. All answers in "other" category were taken into account and used during the data analysis process. Due to distance and sparse populations, no surveys were collected at Nye County so the Team relied solely on literature review and key informant interviews for this community.

Key informant interviews were important to understand what the experts had to say about accessibility to the CoC in the target communities. However, even if questions were asked several times in different ways, it is extremely hard to separate the experts from their personal opinions. North Las Vegas and Las Vegas Wards 3 and 5 are extremely fluid among themselves and the rest of the Las Vegas Valley. Therefore, the Team decided that key informant interviewees did not have to work or reside in the target communities so long as they worked with, and offered services to, individuals in the target communities. The exception to this was Nye County, where interviews were conducted specific to that community.

Focus groups were a good insight into what survivors thought of the health care system. However, due to the convenience sample, they did not belong to any of the target communities. Nevertheless, the Community Profile Team still thought their input was valuable because there are few treatment facilities in Clark County and, regardless of where one lives, they will all use the same ones. Because survivors in the focus groups did not live in the target communities, the Team is not implying that the survivor focus group is a representation of survivors in the target communities, but rather a representation of survivors who had health insurance.

An extensive document review of thirteen documents was carried out in order to gain more information about Nye County. Even though reviewing documents, especially peer-reviewed journal articles, provided reliable information, the information gathered is not necessarily specific to Nye County and, therefore, the Team had to make generalizations with the literature that was available.

North Las Vegas, Clark County

The main barrier to mammography screenings is lack of health insurance and that women do not think it is necessary. The majority of women who received a mammogram did so under medical advice, thus emphasizing the importance of health care providers in educating individuals. Due to the cultural diversity of this city, it is important to also provide culturally sensitive classes for patients and classes in cultural competence for health care professionals.

Las Vegas Ward 3 and Ward 5, Clark County

Much like in North Las Vegas, Ward 3 and Ward 5 also present the lack of health insurance as the primary reason why women do not access mammography screenings. Also similar with North Las Vegas, Las Vegas Wards 3 and 5 residents rely on their health care providers to let them know when to get a mammogram. Individuals in this community feel as if they lack education. Health fairs and health care providers should be used as a point of contact to encourage individuals to attend health workshops.

Nye County

Nye County has the most elderly population in Nevada, thus increasing their need for medical services and risk factors for breast cancer. However, due to the rural nature of the county and outmigration of younger generations, services are few and far between. Most individuals need to travel long distances to Las Vegas or California for health screenings. Nye County is also ranked as one of the unhealthiest counties of Nevada, mostly due to social factors such as education and unemployment percentages. Therefore, because of the lack of public transportation, lack of education and lack of resources, individuals do not necessarily have health insurance or they do not access health services due to distance and lack of transportation. Relationships with their primary health care providers are viewed as an important asset for positive health results and breast cancer patients value it very much. Unfortunately, in order to access treatment patients must travel long distances, and this is the major cause of stress among breast cancer survivors and co-survivors.

Breast Health and Breast Cancer Findings of the Target Communities

Komen Southern Nevada's service area has a breast cancer incidence rate comparable to that of the United States as a whole. For the Affiliate service area, incidence rates were lower among Blacks/African-Americans than Whites and also lower among Asian Pacific Islanders than among Whites. There was not enough data about AIANs to compare incidence rates with the national incidence rate. Incidence rates were also higher among non- Hispanic/Latina women than among Hispanic/Latina women. On the other hand, incidence rate trends in Southern Nevada were higher than national trends. Death rates due to breast cancer in the Affiliate service area were not significantly different than national rates or the State of Nevada as a whole. Death rates among Blacks/African-Americans were higher than among Whites and lower among APIs than among Whites. There wasn't enough information to analyze rates among AIANs. The death rate among Hispanics/Latinas was lower than among non-Hispanics/Latinas. As for late-stage incidence rates in the Affiliate's service area, they were overall lower than in the US, however, late-stage incidence trends were higher than the national trend. Comparable to national rates, late-stage incidence rates among Blacks/African-Americans were higher than among Whites. Late-stage incidence rates were lower among APIs than Whites in the service area. Contrary to national rates, where late-stage incidence rates were higher among Hispanic/Latinas than non-Hispanic/Latinas, in the Affiliate service area late-stage incidence rates were lower among Hispanic/Latina women than among non-Hispanic/Latina women.

Overall breast cancer screening proportions were similar between Komen Southern Nevada's service area, the State of Nevada as a whole and the US. Mammography screening proportions were not significantly different between race and ethnic groups within the service area.

Two indicators from Healthy People 2020 were used in the Quantitative Data Section in order to understand which counties within the Affiliate's service area were of higher priority. The two indicators used were years needed to achieve reduction in breast cancer death rates per 100,000 individuals and years needed to reduce breast cancer late-stage diagnosis rates per 100,000 individuals to reach HP2020 targets. The two counties that were identified as having highest priority were Nye County, which had the highest priority, followed by Clark County. Other counties in the Affiliate's service area did not have enough cases to formulate trends, therefore, they could not be ranked.

The Community Profile Team selected target communities based on several factors, such as unemployment percentages, poverty percentages, linguistic isolation, screening percentages, etc. Three communities were selected as the Affiliate's target communities: North Las Vegas in Clark County, Las Vegas Wards 3 and 5 in Clark County and Nye County. The wards in Las Vegas and North Las Vegas were selected due to their high level of unemployment, the large population of foreign-born individuals and individuals who are linguistically isolated. Furthermore, there was a large percentage of the population under the poverty line. As the highest priority county in the Affiliate's service area according to HP2020 indicators, Nye County was selected as a target community because of its characteristics as a rural region with an aging population and high level of individuals under 100 percent of FPL.

North Las Vegas and Las Vegas Ward 3 and Ward 5 are in the most urbanized region of the state. North Las Vegas, Las Vegas and Henderson are conglomerated into one large urban center. The Health Systems Analysis in North Las Vegas and Wards 3 and 5 of Las Vegas revealed that, often, the CoC ended with screening after a CBE. There were few facilities in these communities offering mammograms and even fewer options for those women who were uninsured or underinsured. There were only three treatment centers in the Las Vegas valley and none of them were located within the target communities. Similarly, although there were survivor support services in the valley and they often assisted women in the target communities, most of them were not located in the target communities. Therefore, cancer survivors and their families had to travel longer distances to receive any sort of support, as well as low-cost or free screenings. Yet another barrier in these two communities was cultural. Clark County is one of the most diverse counties in the US and the target communities have large numbers of foreign-born and linguistically isolated individuals. Because of linguistic or cultural barriers with their health care providers, individuals often choose not to seek medical help unless it is an emergency. Similarly, a lot of these individuals presented a lack of understanding of the health care system and how to navigate it. Therefore, these individuals often underused some resources or wasted others, such as unnecessary or preventable emergency room visits.

As for Nye County, one of the most rural counties in Nevada, the CoC ended after screening. With such rural communities, often the only source of health care was travelling nurses or community nurses, who could offer no more than clinical breast exams (CBEs). There were two locations in the entire county where one could get screening mammograms. However, if a mammogram came back showing something suspicious, patients had to travel long distances, often over one hundred miles, for follow-up tests and treatment. The need to travel so far, even just for regular screenings, was a barrier for many. Support services for these individuals were limited and scarce. The main service offered was financial assistance for breast cancer patients at the health departments in Tonopah and Pahrump through a Komen Southern Nevada small grant.

Nevada's version of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), Women's Health Connection (WHC), is managed through a sub-grant by Access to Healthcare Network (AHN). One of the most restrictive states, Nevada's WHC has age limitations and treatment eligibility restrictions, depending on the place of diagnosis. Due to lack of funding, AHN only sees women 40-65 years old. For women ages 40 to 49, AHN provides a yearly pap smear, pelvic exam and CBE. A mammogram will only be done if abnormalities were found during the medical visit. Women 50 and older will also have a mammogram in addition to all the other aforementioned tests. Those women that are diagnosed with breast cancer are fast-tracked to Medicaid. However, if a woman is not diagnosed at an AHN-approved center, she will not be eligible for Medicaid and, therefore, she might have to repeat previous tests at an approved center. WHC does not cover undocumented populations either, thus leaving a large number of young and foreign-born women with no low-cost or free access to screening tests.

The Nevada Comprehensive Cancer Control Coalition strives to provide a comprehensive network of screening, diagnostics and treatment facilities in order to reduce cancer risk, access to quality screening and treatment and, overall, improve the quality of life of cancer patients and survivors. Although very active in Northern Nevada, the Nevada Comprehensive Cancer Coalition is not as active in the Southern half of the state. Komen Southern Nevada has been an

active member of a stewarding committee to improve the coalition's network in Southern Nevada.

With Medicaid expansion up to 138 percent FPL and the state based marketplace, it was estimated that the ACA would decrease the percentage of uninsured from roughly 25 percent to about 19 percent of the Nevada population (Kaiser Foundation, 2014). Estimates also indicated that two-thirds of the state's uninsured would be eligible for Medicaid after the expansion and the remaining would be eligible to shop at Nevada Health Link for insurance. The increased availability of affordable health care insurance does not mean automatic registration of those individuals who are eligible. Further, with such a large undocumented population, Clark County also faces the challenge of accommodating individuals who are not eligible for health insurance. Medicaid expansion has resulted in a larger influx of patients and higher demand for health care providers.

WHC worked hard during 2013 and 2014 to make all of their clients aware of the ACA and different insurance possibilities, whether that was Medicaid or health plans through the Exchange. Many individuals need guidance, not just to sign up for a health plan or Medicaid, but also to navigate the health system as this is often the first time with health insurance for many. In preparation for the qualitative section of the Community Profile, the Team developed the following questions:

1. Do individuals in the target communities have knowledge about breast health and risk reduction behaviors?
2. Does an individual's place of residence alter their understanding of breast health?
3. What are the main barriers stopping individuals in the target communities accessing breast health care?
4. What are the best ways to reach individuals in the target communities?

Findings in North Las Vegas indicate that women answering the survey who did not get mammograms didn't do so because they thought they were too young, their doctor didn't recommend it or they didn't have health insurance. Although surveys showed that over 90 percent of women who knew about recommended screening guidelines had had at least a mammogram, there was a perception that education was lacking in the community. Interviews revealed that it might be due to cultural barriers or due to the fact that individuals only visited their health care providers in case of emergency. Health fairs were welcomed as a point of information. However, interviewees emphasized the importance of health care providers, patient navigators and learning workshops where both individuals who have health care coverage for the first time, or are foreign-born, can learn how to navigate the health care system.

In Las Vegas Ward 3 and Ward 5, survey participants also claimed age and lack of health insurance as the main barriers for accessing screening mammograms. The majority of women who had had a mammogram did so after medical advice or because they were symptomatic. In fact, less than 10 percent of age-appropriate women in this community had a mammogram as a routine check-up. Individuals in the target communities stated that lack of education was the main reason for which women bypassed their mammograms, followed by the cost of a mammogram. Even women who did undergo mammograms expressed a lack of understanding and expressed a desire to learn more about breast health. The sentiment was shared by survivors in the focus groups, who felt like there wasn't enough information for them from the moment they were diagnosed. Key informant interviewees were concerned about the lack of

knowledge and identified the need for culturally appropriate educational outlets, where health fairs may be the first point of contact.

Nye County presents the highest priority in the Affiliate's service area. This county has also scored low in other health and wellness indicators. As such a rural community, the two main barriers to care in Nye County are distance and lack of insurance and/or economic means. Because many individuals do not own a private vehicle and there is no public transportation, people may not get to medical check-ups or treatment appointments as often as they should. Studies show that rural women are less likely to get their screening mammograms than their urban counterparts. In such communities, primary health care providers provide a pivotal role to the diagnosis and treatment of breast cancer. However, often individuals do not even enter the CoC due to difficulty accessing health care facilities or providers. For those who are diagnosed with breast cancer, travel for treatment and medical appointments becomes a constant source of stress, especially if other family members depend on them or if the patient runs the family business.

Mission Action Plan

The Mission Action Plan includes problem statements, priorities and objectives for the target communities in the Affiliate service area. Due to the fact that two of the target communities, North Las Vegas and Las Vegas Wards 3 and 5 are extremely fluid and have similar problems, the Team determined that one problem statement is sufficient for both communities. Similarly, because the two communities are geographically very close, the Team felt that priorities and objectives could be shared, as it is nearly impossible to separate the two communities; city limits between North Las Vegas and Las Vegas are merely a street and, for those not looking at a map, it is hard to tell at times whether they are in North Las Vegas or Las Vegas. In order to define priorities and objectives, the Mission Manager drafted a list of possibilities. The list was then distributed among the Affiliate's staff and Board and they were subsequently invited to add priorities/objectives. All the suggestions were then unified into one master document and summarized. The Mission Action Plan was drafted based on that document.

Nye County

Problem Statement: Nye County has high late-stage diagnosis rates. According to the quantitative data, 72.3 percent of women ages 50-74 reported having had a mammogram in the past two years. This might be due to the fact that, according to the health systems analysis data, the CoC often ends after a CBE and patients need to travel long distances for mammograms or follow-up tests. The qualitative data suggests that the lack of public transportation in Nye County, the lack of health insurance and high levels of poverty are a major deterrent for men and women to have regular mammography screenings.

Priority 1: Increase regular mammography screening percentages in Nye County by strengthening the Affiliate's current partnership with the Nevada Health Centers Mammovan, the health departments in Pahrump and Tonopah and the community nurses' clinics.

> *Objective 1:* By December 2015, arrange a meeting with at least three stakeholders to create an action plan that will ensure regular visits of the Mammovan throughout the county so that women who wish to get a screening mammogram do not have to drive for more than an hour each way.

Objective 2: By May of 2016, distribute a comprehensive community contact list with key individuals that can assist marketing the Mammovan in at least five communities in Nye County in cooperation with Nevada Health Centers and the health departments in Pahrump and Tonopah.

Objective 3: By December 2016, encourage the Mammovan to expand their visits to Nye County by at least one additional event by providing assistance with finding contacts in the communities and advertising the arrival of the Mammovan.

Objective 4: By the end of FY 2018 create an evaluation plan in cooperation with the Mammovan and the health departments in Pahrump and Tonopah that will analyze the Mammovan's efficacy in reaching new clients and retaining old ones in at least five visits during the following fiscal year.

Priority 2: Eliminate barriers that impede women with suspicious mammograms in moving along the CoC.

Objective 1: Review the travel scholarship small grant that was awarded to the health department in Pahrump by Komen Southern Nevada and determine how many individuals benefited from it in order to determine its continuity by January 2016.

Objective 2: The FY2016 Small Grants Request for Application (RFA) will include programs that provide transportation services for residents of Nye County to receive breast cancer services as a funding priority.

North Las Vegas and Las Vegas Wards 3 and 5, Clark County

***Problem Statement*:** As the most diverse county in Nevada, many residents of North Las Vegas and Las Vegas Wards 3 and 5 do not receive culturally appropriate medical care, which causes trends in late-stage diagnosis to be higher than national trends. The quantitative data indicates that over one in five residents in North Las Vegas are foreign-born and about 40.0 percent of individuals in North Las Vegas speak a language other than English in the home, which indicates a high level of cultural diversity. Las Vegas Ward 3 is home to the largest percentage of Hispanics/Latinos in the City of Las Vegas. Unfortunately, a large portion of the population is undocumented. The health systems analysis data shows that there are limited options for mammography screenings in North Las Vegas, in particular, for those individuals who do not have health insurance. There is the need to travel to different parts of the city for screenings. Furthermore, the qualitative data suggests that due to lack of understanding of the US health care system, men and women do not access preventive health care services, but rather go to the emergency room when there is no other option.

Priority 1: Increase culturally sensitive outreach by providing small group information workshops to individuals of different cultural/ethnic backgrounds in cooperation with local organizations in North Las Vegas and Las Vegas Wards 3 and 5.

Objective 1: By December 2015, identify at least three organizations that work with ethnic minorities in North Las Vegas and Las Vegas Wards 3 and 5 who can assist with outreach efforts to ethnic minorities.

Objective 2: Recruit at least five volunteers from North Las Vegas and five volunteers from Las Vegas Wards 3 and 5 that speak a language other than English and train them on Komen BSA messaging by March 2016.

Objective 3: By 2017, form at least three partnerships in North Las Vegas and three partnerships in Las Vegas Wards 3 and 5 with predominantly Hispanic/Latino, Black/African-American and Asian associations where BSA messaging can be promoted (i.e. religious organizations, cultural groups, schools, etc.).

Objective 4: In FY 2018, hold at least four culturally sensitive workshops in North Las Vegas and Las Vegas Wards 3 and 5 that are aimed specifically at navigating the health care system for breast care in cooperation with local organizations.

Priority 2: Enhance cultural competencies of health care providers throughout the Las Vegas Valley that provide services to resident of North Las Vegas and Las Vegas Wards 3 and 5.

Objective 1: In FY 2016, identify and contact at least three health organizations that provide services to resident of North Las Vegas and Las Vegas Wards 3 and 5 that are culturally competent and serve a diverse population.

Objective 2: In cooperation with the aforementioned organization(s), hold at least four cultural competency workshops for health care providers that provide breast cancer services for residents of North Las Vegas and Las Vegas Wards 3 and 5 during FY 2017 and FY 2018 (two workshops per fiscal year).

Priority 3: Increase the number of health services and providers available in North Las Vegas and Las Vegas Wards 3 and 5 by funding health system partnerships to increase access to services.

Objective 1: By December 2015, hold at least two grant writing workshops in North Las Vegas and Las Vegas Wards 3 and 5 aimed at existing breast health providers identified on the resource map to inform the providers of potential funding opportunities.

Objective 2: For FY 2016, the Community Grant Request for Application (RFA) will include patient navigator programs aimed specifically at working with minority populations and linguistically isolated individuals living in North Las Vegas and Las Vegas Wards 3 and 5 as a funding priority.

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