# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table of Contents</td>
<td>2</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>3</td>
</tr>
<tr>
<td><strong>Executive Summary</strong></td>
<td>5</td>
</tr>
<tr>
<td>Introduction to the Community Profile Report</td>
<td>5</td>
</tr>
<tr>
<td>Quantitative Data: Measuring Breast Cancer Impact in Local Communities</td>
<td>6</td>
</tr>
<tr>
<td>Health Systems and Public Policy Analysis</td>
<td>7</td>
</tr>
<tr>
<td>Qualitative Data: Ensuring Community Input</td>
<td>8</td>
</tr>
<tr>
<td>Mission Action Plan</td>
<td>9</td>
</tr>
<tr>
<td><strong>Introduction</strong></td>
<td>15</td>
</tr>
<tr>
<td>Affiliate History</td>
<td>15</td>
</tr>
<tr>
<td>Affiliate Organizational Structure</td>
<td>16</td>
</tr>
<tr>
<td>Affiliate Service Area</td>
<td>18</td>
</tr>
<tr>
<td>Purpose of the Community Profile Report</td>
<td>21</td>
</tr>
<tr>
<td><strong>Quantitative Data: Measuring Breast Cancer Impact in Local Communities</strong></td>
<td>22</td>
</tr>
<tr>
<td>Quantitative Data Report</td>
<td>22</td>
</tr>
<tr>
<td>Selection of Target Communities</td>
<td>35</td>
</tr>
<tr>
<td><strong>Health Systems and Public Policy Analysis</strong></td>
<td>38</td>
</tr>
<tr>
<td>Health Systems Analysis Data Sources</td>
<td>38</td>
</tr>
<tr>
<td>Health Systems Overview</td>
<td>39</td>
</tr>
<tr>
<td>Public Policy Overview</td>
<td>47</td>
</tr>
<tr>
<td>Health Systems and Public Policy Analysis Findings</td>
<td>64</td>
</tr>
<tr>
<td><strong>Qualitative Data: Ensuring Community Input</strong></td>
<td>65</td>
</tr>
<tr>
<td>Qualitative Data Sources and Methodology Overview</td>
<td>65</td>
</tr>
<tr>
<td>Qualitative Data Overview</td>
<td>68</td>
</tr>
<tr>
<td>Qualitative Data Findings</td>
<td>77</td>
</tr>
<tr>
<td><strong>Mission Action Plan</strong></td>
<td>80</td>
</tr>
<tr>
<td>Breast Health and Breast Cancer Findings of the Target Communities</td>
<td>80</td>
</tr>
<tr>
<td>Mission Action Plan</td>
<td>84</td>
</tr>
<tr>
<td><strong>References</strong></td>
<td>88</td>
</tr>
</tbody>
</table>
The Community Profile Report could not have been accomplished without the exceptional work, effort, time and commitment from many people involved in the process.

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Susan G. Komen® Miami/Ft. Lauderdale held its first Race for the Cure® in 1996 and was founded in 1999. After hosting a Race for the Cure in Miami for three years, a dedicated group of volunteers put together a plan to continue their hard work on a year-round basis and the Komen Miami/Ft. Lauderdale was born. The Affiliate serves over four million people in three counties in the southernmost point of Florida, including Broward, Miami-Dade and Monroe Counties. Since that time, the Affiliate has granted over $9.3 million dollars into its local community through its community and small grants programs. Up to seventy-five percent of the Affiliate’s net income goes toward funding grants to health care organizations, public health agencies and community groups that provide breast health education, breast cancer screening and treatment programs for uninsured, medically underserved women and men in Broward, Miami-Dade and Monroe Counties.

Currently, the Affiliate funds 27 local grantees with close to $800,000 in funding, while funding approximately $285,000 in Komen National Research Programs. The grantees range from large hospital systems to small support groups and free clinics. One of the Affiliate local grantees, Save Our Sisters (known as SOS) is a local dragon boat team that is making an international splash! This group of survivors recently hosted an international dragon boat festival with more than 3,000 breast cancer survivors and 105 teams from around the world. For survivors that are looking for a local support group that combines physical activity with the comradery of sister survivors, this group promotes healthy living and welcomes all survivors.

Komen Miami/Ft. Lauderdale plays an active role in the local cancer community by collaborating with the Florida Cancer Control and Research Advisory Council (CCRAB), which was established by the Florida Legislature in 1979 with the purpose of advising the Legislature, Governor and Surgeon General on ways to reduce Florida’s cancer burden. The Affiliate is also active in the Komen Florida Public Policy Collaborative with two staff members actively participating in all Collaborative monthly meetings and projects. The Affiliate Executive Director is the current Chair for the Collaborative. The Komen Florida Public Policy Collaborative is made up of representatives of the six State of Florida Susan G. Komen Affiliates with the goal of addressing issues and legislation that are critical to breast cancer issues in the State of Florida.

The 2015 Community Profile Report will allow the Affiliate to define specific strategies to address gaps and barriers to accessing critical breast health services as well as help in assessing the availability and quality of those services. Pinpointing the population that is most at risk of dying of breast cancer or late stage diagnosis and comparing the service area data to the Healthy People 2020 breast cancer targets helps determine the priority areas of the Affiliate. By determining set priorities in each Affiliate service area, this report will allow the Affiliate to make data-driven decisions about how to use its resources in the best way while making the greatest impact. The findings in this report will not only direct future Affiliate grants funding, but also impact public policy initiatives, community mobilizing activities and the development of strong collaborations and partnerships throughout the service area. This will create synergy between the Affiliate’s Mission-related strategic plans and operational activities.
The Community Profile Report will be hosted on the Affiliate website for community review as well as shared with the extensive database of donors, volunteers, current and past grantees, county and state health departments, healthcare systems, community organizations, cancer collaborative and legislators in the service area.

**Quantitative Data: Measuring Breast Cancer Impact in Local Communities**

The findings from the Quantitative Data Report that were reviewed and analyzed by Susan G. Komen Miami/Ft. Lauderdale were geared toward making the Affiliate service area compliant with the Healthy People 2020 initiative. Healthy People 2020 is a major federal government initiative that provides specific health objectives for communities and the country as a whole. The Affiliate analyzed the statistics provided for the Affiliate service area and identified four priority targets based on the time needed to meet Healthy People 2020 targets for breast cancer, as well as other local priorities based on community knowledge not included in the statistics or data given in the Quantitative Data Report.

The selected priority target communities for the Affiliate are:
- Broward County: Black/African-American females and women who partner with women
- Miami-Dade County: Women who are linguistically isolated/foreign born
- Monroe County

Broward County has a substantially higher Black/African-American female population than the other two counties in the service area with a slightly higher percentage of residents who are unemployed. While the Affiliate service area as a whole has a substantially higher percentage of the population age 40-64 living without health insurance (32.6 percent), Broward County has a substantially larger percentage of this population without health insurance than the United States average of 16.6 percent.

There is limited data on women who partner with women, however, according to the Williams Institute Florida Census Snapshot of 2010, Broward County ranks number two in the state in same sex couples with an estimated 11.33 per 1,000 households. Broward County also has three out of the top four cities in the state rankings of highest percentage of same sex couples per 1,000 households. Women who partner with women are believed to have a higher risk of breast cancer than other women because they usually have more risk factors. They are less likely to bear children or to have children earlier in life and have a higher obesity and alcohol use rate.

Upon review, none of the three counties in the Affiliate service area have a combined Highest or High Needs priority classification based on the projected time to achieve Healthy People 2020 breast cancer targets. Two of these communities do have a highest rating of thirteen years or longer on one of the components of the Healthy People 2020 breast cancer targets.

Miami-Dade County is the most populous county in the Affiliate service area with over half of the Affiliate service area population. Miami-Dade County is currently on track to meet the Healthy
People 2020 breast cancer death rate target and was projected to meet the late-stage incidence target goal in two years. Miami-Dade County is made up of 65 percent Hispanic/Latina residents with 51.2 percent being foreign born and 26.7 percent being linguistically isolated. It is imperative that Komen Miami/Ft. Lauderdale continue to find ways to impart breast health information and materials that communicate in the various languages and learning styles of this demographic, as well as embrace the different cultures present to effectively service this priority area.

Monroe County is the southernmost county in the United States and Florida with the Florida Keys, a chain of low lying islands connected to the mainland by U.S. Highway 1, which ends 150 miles south of Miami in Key West. Due to the geographical layout of Monroe County, medical access is limited with 100 percent of the population listed as living in medically underserved areas. Monroe County has a projected time of 13 years or longer to meet the Healthy People 2020 death rate target goal, but currently is on track to meet the late-stage incidence target goal. The Monroe County death rate and trend of 25.1 per 100,000 is substantially higher than the Healthy People 2020 rate of 20.6 per 100,000 as well as the Komen Miami/Ft. Lauderdale service area rate of 21.1 per 100,000.

**Health Systems and Public Policy Analysis**

For two of the counties in the Komen Miami/Ft. Lauderdale service area, Broward and Miami-Dade Counties, the number and location of hospital systems, free clinics and supporting organizations are abundant. The Affiliate currently partners with more than 20 organizations in each of these two counties to provide breast health services and to ensure that the continuum of care is met for these populations. In both of these counties, the Affiliate is working to educate the population on the available resources and strengthen the patient navigation network. While the Affiliate partners through its grants program with 17 hospitals in Broward County and 18 hospitals in Miami-Dade County, there are still a few that have no connection to the Affiliate. Three of the hospital systems currently have new Cancer Institutes under construction so the outlook for more breast cancer dedicated services in both of these counties are bright.

Monroe County is comprised of three main segments; upper, middle and lower keys. While there is at least one hospital and one community health center in each segment, most of the other breast health services are located in Key West or on the mainland Miami. This translates into a three to four hour drive for most residents. Screening services are available in 86 percent of the health centers in Monroe County but only 27 percent provide diagnostic tests and a mere 18 percent provide treatment options. As such, providing easy access to the full continuum of care is a major concern of the Affiliate.

The Komen Miami/Ft. Lauderdale service area is comprised of the number one and number two most populated counties in the State of Florida. Greater emphasis needs to be placed on Public Policy efforts and developing those political and impactful relationships. The Komen Florida Public Policy Collaborative will be discussing ways to enhance the mission and build stronger relationships with state politicians at the annual collaborative meeting. With the successful
passing of the Oral Parity Bill in 2014, the Collaborative has taken a leadership role in the cancer arena in the State. Each Florida Affiliate has taken steps to educate and train the staff and volunteers to ensure that the message is a cohesive one and stays within the guidelines of the National Advocacy Policies.

**Qualitative Data: Ensuring Community Input**

The questions that were asked of participants were selected based upon the contextual nuances documented in the Quantitative Data and Health Systems and Public Policy Analysis reports. These reports offered a visual representation of the available services throughout the regional area and documented the gaps of services and proximity of the resources to the breast cancer hot spots in the region. The questions asked were designed to build on the previous reports by presenting the community perspective on how effective these services are when it comes to meeting the needs of the women in the region and the extent that the services offered meet the screening, diagnostic and treatment needs to overcome breast cancer.

The Komen Miami/Ft. Lauderdale Community Profile Team decided to approach the Qualitative Data by focusing on two data collection methods: key informant interviews and focus groups. The team developed a “Qualitative Question Bank” that addressed access to care, barriers, disparities, survivorship and healthcare system issues (i.e. bottleneck, capacity and timeliness issues). A number of additional resources were developed to aid in the data collection process such as scripts, focus group invitations, consent and demographic forms. These were also professionally translated into both Spanish and Creole to assist in the data collection of the priority area of linguistically isolated/foreign born population in Miami-Dade County.

Of the four priority areas of the Komen Miami/Ft. Lauderdale service area, disparities were most evident between two distinct groups. The first group being the linguistically isolated and foreign born women of Miami-Dade County, who were newly immigrated into the United States. These women remain outside the local continuum of care for many reasons including the inability to communicate with providers, fear of discovering breast cancer, cultural norms that do not promote health prevention activities, immigration status and lack of education about breast cancer prevention.

The second disparate group represents Black/African-American women in Broward County that remain outside of the continuum of care. Black/African-American women are more likely to be diagnosed with late-stage breast cancer than White women. Particular segments of this county have rates of late-stage diagnosis that not only exceed other regions of the county, but also that of state and national rates. This group relayed several reasons as to their reluctance to engage in the healthcare system such as competing priorities, lack of insurance or financial resources, fear and culture of silence.

Women who partner with women in Broward County felt that most healthcare professionals were lacking in cultural competency training. By simply altering the type of questions asked on an intake form and being culturally sensitive, most healthcare providers could not only receive
more accurate and relative information on their patients but could provide more data on the 
needs of this segment of the population. With the passage of same sex marriage laws in 
Florida, becoming more culturally competent is a priority to be able to address the needs of this 
population.

For Monroe County the findings suggested that while the number of available local resources for 
breast health diagnosis and treatment was a deterrent to receiving breast health care, lack of 
trust in the local healthcare facilities and/or providers were just as important. In a community 
with few resources available, any negative word of mouth stories can have a major impact.

All groups express that fear and cultural behavior is a barrier to obtaining breast health services. 
While the Affordable Care Act has allowed more people the ability to enroll in affordable health 
insurance coverage, many of these plans are not being accepted by healthcare providers. With 
the exception of women who partner with women in Broward County, all groups touched upon 
the lack of insurance or financial resources for breast health service and treatment as a barrier 
to proper care.

**Mission Action Plan**

For the Affiliate as a whole, both the late-stage incidence rate and death rate are higher amount 
Black/African-American women that White women, and Broward County, in particular, is home 
to a relatively large Black/African-American population. Even though there are more than 
enough breast cancer screening, diagnostic and treatment resources readily available, there 
appears to be a universal unawareness of those resources in the Black/African-American 
community. The same findings appeared within the women who partner with women 
population, but they felt that a lack of sensitivity to their lifestyle was a barrier to care.

Komen Miami/Ft. Lauderdale needs to provide breast health education and information on 
available resources to Black/African-American women in Broward County to ensure that 
screening information and practices will not only be effectively received, but also acted upon. 
The Affiliate needs to provide cultural competency training for health care providers and staff 
working with the LGBT community in Broward County.

Miami-Dade County population is 65 percent Hispanic/Latina, while another large percentage 
are Haitian/Caribbean. Of that number, 51.2 percent are foreign-born and 26.7 percent are 
linguistically isolated, both of which are significantly higher than the national average. There are 
an abundance of local health centers and free clinics, however women in this community could 
not readily identify where to get free/low-cost services. The second problem area that this 
report has uncovered is the large population of undocumented women in Miami-Dade County 
who are fearful of being deported if they seek health care services.

Komen Miami/Ft. Lauderdale needs to increase breast health provider information outreach and 
education to the linguistically isolated/foreign born population of Miami-Dade County as well as
inform this population of providers who screen and treat the undocumented population without regard to immigration status.

Monroe County has good support with screening facilities and availability. The bigger issue appears when diagnosis and treatment support is needed. Most of the women expressed a lack of trust in the local medical community that stemmed from a lack of reliable medical resources. Komen Miami/Ft. Lauderdale needs to increase the number of health service providers available in Monroe County by establishing and funding, health system partnerships to increase access to services.

The objectives of Komen Miami/Ft. Lauderdale are as follows:

**Broward County** – In FY16, meet with service providers that work with the Black/African-American and the LGBT communities to develop an action plan on how to improve breast cancer outreach, cultural competency and education. The Affiliate will develop an outline of education and competency needs to be addressed to ensure that the community needs are met. By starting with the Affiliate’s grantees that are education and service providers there will be a partnership in accomplishing these goals and changes. Including these needs as part of the mandatory grants workshops this fall should give a measurable outcome by the end of the next grants cycle.

**Miami-Dade County** – In FY16, meet with breast health service providers that work with linguistically isolated/foreign-born women to develop an action plan on how to improve breast cancer outreach in the target community and for FY17 update the Affiliate grants RFA to include outreach requirements for anyone serving this population.

By FY17, develop new collaborative relationships with local groups (i.e. embassies, consulates, immigration groups, etc.) who work with the undocumented population of Miami-Dade County and then survey community health centers in the county to establish a resource list for undocumented patients.

**Monroe County** – By FY17, meet with local breast health providers in Monroe County to establish, and possibly fund, patient-navigation programs targeting women diagnosed with breast cancer as well as encourage more providers to apply for Komen Miami/Ft. Lauderdale grant funding.

**Komen Miami/Ft. Lauderdale Service Area** - In the Komen Miami/Ft. Lauderdale service area as a whole, the percentage of residents living at 250 percent below the poverty line is higher than the national average, as is the unemployment rate. The percentage of residents living with no health insurance is nearly double that of the national average. When considering the implications of the Affordable Care Act (ACA), of particular concern are the residents who fall in the “Medicaid Gap”, undocumented women who are not eligible for the ACA, and women who are uninsured/underinsured. A common theme among the service area is the cost of care and lack of insurance. Even for those with insurance, many have been denied care because of the
lack of physicians or service providers accepting their insurance or the financial burden of high deductibles. While screening services are often available to this population for free, if diagnosed with breast cancer there are very few resources available for treatment and other costs that occur with a breast cancer diagnosis. The Affiliate needs to increase funding to providers for diagnostics and treatments in the service area.

By 2018, a key funding priority in the Affiliate RFA will be funding free or low-cost treatment programs in the service area while meeting with treatment partners to try and negotiate lower costs for breast cancer treatment options.

Broward County

Problem Statement: For the Affiliate as whole, both the late-stage incidence rate and death rate are higher among Black/African-American women than White women, and Broward County, in particular, is home to a relatively large Black/African-American population. The health system analysis found that breast cancer screening, diagnostics and treatment options are readily available throughout the county. However, breast cancer survivors and health care providers indicated that among the Black/African-American population there is a universal unawareness of breast cancer and the available breast health resources in the community. If women do not understand the risk and nature of the disease, they will not know what health information and/or services to seek out.

Priority: Provide education on breast health and available resources to Black/African-American women in Broward County, so as to ensure that screening information and practices will not only be effectively received, but also acted upon.

Objectives
- In FY16, meet with service providers in Broward County that work with the Black/African-American community to develop an action plan on how to improve breast cancer outreach and education in this target community.
- By 2017, update Affiliate RFA to include outreach requirements for anyone serving the Black/African-American community in Broward County.

Problem Statement: Very little statistical data on women who partner with women is available. However, because women who partner with women are less likely to bear children and exhibit riskier lifestyle choices such as alcohol use and obesity, they are believed to have more risk factors for breast cancer than other women. Broward County ranks second in the state in same sex couples, and is home to three of the top four cities in the state with the highest percentage of same sex couples. According to the health system analysis, two of these cities have hospitals within the city, and the third has one within five minutes of the city limits. Community partners felt that geographically the services are in place, but that there is a lack of sensitivity among health care providers when it comes to working with the LGBT community.
**Priority:** Provide cultural competency training for health care providers and staff working with the LGBT community in Broward County.

**Objectives**
- By 2016, meet with key LGBT community leaders to determine best practices that should be put in place in all health care facilities serving the LGBT community in Broward County.
- By 2017, fund a cultural competency “train the trainer” program to be disseminated to all providers serving the LGBT community in Broward County.

**Miami-Dade County**

**Problem Statement:** In the target community of Miami-Dade, 65.0 percent of the residents are Hispanic/Latina, while another large percentage are Haitian/Caribbean. Of that number, 51.2 percent are foreign-born and 26.7 percent are linguistically isolated, both of which are significantly higher than the national average. Statistics show that Hispanics/Latinas tend to be diagnosed with late-stage breast cancers more often than Whites. Due to cultural norms and language barriers, the Haitian/Caribbean population faces high late-stage diagnosis rates as well. The health system analysis indicated that there is an abundance of health centers throughout Miami-Dade County, including free clinics which are particularly important in this population, with a vast majority of them providing screening and diagnostic services. However, women in the community could not readily identify where to get free/low-cost services, while providers expressed that unlike other communities where medical resources are lacking, in Miami-Dade it is education and health literacy that are lacking.

**Priority:** Increase breast health outreach to foreign-born/linguistically isolated communities in Miami-Dade County.

**Objectives**
- In FY16, meet with service providers in Miami-Dade County that work with linguistically isolated/foreign-born women to develop an action plan on how to improve breast cancer outreach in this target community.
- By 2017, update Affiliate RFA to include outreach requirements for anyone serving linguistically isolated/foreign-born women in Miami-Dade County.

**Problem Statement:** Miami-Dade has a large population of undocumented women, who are not accounted for in the Census data due to their illegal immigrant status. These women, who are most often Hispanic/Latina and/or Caribbean/Black, both have higher late-stage incidence rates than White women. The health system analysis found that the health systems exist in the community; however, there is a shortage of centers in South Miami-Dade, where a large immigrant population resides. Women in the community and health care providers indicated that immigration status was a true challenge because undocumented women feel like there is no place to go, and worry that if they disclose their illegal status they will be deported. Added to
that, with the abundance of paperwork required at free clinics, the system becomes a burden to
them, oftentimes making the requirements for free service too cumbersome.

**Priority:** Identify health care providers in Miami-Dade County that offer services to
women regardless of immigration status, and work on streamlining both the
communication of these services and the registration process to receive services.

**Objectives**
- By 2017, develop new collaborative relationships with local groups (i.e. embassies, consulates, immigration groups, etc.) who work with the
undocumented population of Miami-Dade County.
- By 2017, survey community health centers in Miami-Dade County to establish
resource list for undocumented patients.

**Monroe County**

**Problem Statement:** In the target community of Monroe County, the death rate is higher than
both the Affiliate as a whole and the state. Due to its geographical layout, 100.0 percent of the
population is listed as living in medically underserved areas. Monroe also has a higher
percentage of residents living with no health insurance when compared to the national average.
The health system analysis revealed that the county as a whole is severely lacking in medical
resources. Though there appears to be one hospital in each segment of the county, the bulk of
the health centers and free clinics are in the Lower Keys, which would mean a three hour drive
for those living in the Upper Keys. Of the small number of centers that do exist, only 27.0
percent provide diagnostic services and 18.0 percent provide treatment. Survivors and providers
alike felt that there is good support at the screening stage, but if breast cancer is diagnosed,
there is nowhere to go locally for support. Most of the women expressed a lack of trust in the
local medical community that stemmed from a lack of reliable medical resources.

**Priority:** Increase the number of health service providers available in Monroe County by
establishing, and funding, health system partnerships to increase access to services.

**Objectives**
- By 2017, meet with local providers to establish, and possibly fund, patient-
navigation programs targeting Monroe County women diagnosed with breast
cancer.
- In FY16, heavily promote and host at least two grant writing workshops in
Monroe County, to encourage more health care providers to apply for Komen
funding.

**Service Area (Broward, Miami-Dade, Monroe)**

**Problem Statement:** In the service area as a whole, the percentage of residents living at 250
percent below the poverty line is higher than the national average, as is the unemployment rate.
The percentage of residents living with no health insurance is nearly double that of the national
average. When considering the implications of the Affordable Care Act (ACA), of particular
concern are residents who fall in the “Medicaid Gap,” undocumented women who are not eligible for the ACA, and women who are uninsured/underinsured. A common theme among the service area is the cost of care and lack of insurance. For those insured under the ACA, many have been denied care because not all physicians accept the insurance. While those with no insurance at all said the cost of services was prohibitive and often battles out with other basic needs (food, housing, child care, etc.). Providers agreed that the service area suffers from being underinsured and/or lacking the financial resources to follow through with care. And that while screening services are often available to this group for free, if an uninsured/underinsured woman is diagnosed there are very few places to go for treatment.

**Priority:** Increase free or low-cost treatment options available to uninsured/underinsured women in the Susan G. Komen Miami/Ft. Lauderdale service area.

**Objectives**
- By 2018, a key funding priority in the Affiliate RFA will be funding free or low-cost treatment programs in service area.
- By 2018, meet with treatment partners to try and negotiate lower costs for breast cancer treatment options in the Affiliate service area.

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

In 1982, Nancy G. Brinker founded Susan G. Komen® after promising her sister Suzy that she would do all she could to end the disease that claimed her life. That promise launched the global breast cancer movement. In the years since, Komen has become the world's largest grassroots network of breast cancer survivors and activists working together to save lives, empower people, ensure quality care for all and energize science to find the cures. Today, Susan G. Komen is the boldest community fueling the best science and making the biggest impact in the fight against breast cancer.

Susan G. Komen® Miami/Ft. Lauderdale held its first Race for the Cure® in 1996 and was founded in 1999 on the guiding principle of Komen Headquarters - to combat breast cancer at every front. In the years since, Komen Miami/Ft. Lauderdale has invested nearly $9.3 million into its local community through its community and small grants programs. Up to seventy five percent of the Affiliate’s net income goes toward funding grants to health care organizations, public health agencies and community groups that provide breast health education, breast cancer screening and treatment programs for uninsured, medically underserved women in Broward, Miami-Dade and Monroe Counties.

Each year, Komen Miami/Ft. Lauderdale funds upwards of $900,000 to 30+ grantees, which provide:

- Breast health awareness and education training to nearly 30,000 individuals
- Clinical breast exams to more than 3,000 individuals
- Screening mammograms to nearly 5,000 individuals, many of which are provided via mobile mammography
- Diagnostic services to more than 2,000 individuals
- Treatment to more than 200 breast cancer patients
- Patient navigation to more than 600 patients
- Genetic testing to nearly 75 individuals
- Supportive services, such as group therapy, one-on-one psychotherapy and survivorship support, to more than 2,500 individuals

The remaining 25 percent supports the Komen National Research Programs, which funds groundbreaking breast cancer research, meritorious awards and educational and scientific programs around the world. Because of the incredible breast cancer research being conducted in the Affiliate’s service area, a substantial amount of Komen National grant dollars are returned to the Affiliate’s community, making Komen Miami/Ft. Lauderdale one of few who, over the last eight years, can boast that more than 100 percent of the funds raised locally are spent locally.

In addition to the breast health and breast cancer projects funded through the Affiliate grants programs; Susan G. Komen Miami/Ft. Lauderdale plays an active role in the local cancer community. The Affiliate collaborates with the Florida Cancer Control and Research Advisory Council (CCRAB), which was established by the Florida Legislature in 1979, under Florida Statute 1004.435, with the purpose of advising the Legislature, Governor, and Surgeon General...
on ways to reduce Florida’s cancer burden. CCRAB has four goals, two of which are the priority of the Affiliate – Treatment and Access to Care and Survivorship. Members of the Cancer Community are invited to attend monthly conference calls for each of these goals to provide feedback based on their unique area of expertise and to stay abreast of important cancer-related resources and initiatives in the community. The state is divided into six CCRAB regions. Komen Miami/Ft. Lauderdale falls under the Southeast Florida Cancer Control Collaborative (SFCCC), which is dedicated to improving access to cancer care and decreasing the burden of cancer through a united effort by promotion of education, advocacy and research for the people of Southeast Florida. The SFCCC holds quarterly meetings where members break off into work groups that are aligned with the Florida Cancer Plan. Komen Miami/Ft. Lauderdale concentrates its efforts in these meetings on “Reducing Cancer Disparities.” Komen Miami/Ft. Lauderdale is also active in the Komen Florida Public Policy Collaborative with two staff members actively participating in all Collaborative monthly meetings and projects. The Affiliate Executive Director is the current Chair for this Collaborative. The Komen Florida Public Policy Collaborative brings together representation from all six Florida Affiliates to further issues and legislation that are critical to breast cancer issues in the State of Florida. The Collaborative also participates in Lobby Days that are hosted in the State Capitol and works in partnership with other cancer organization to pass legislation in line with the Komen mission.

**Affiliate Organizational Structure**

The staff of Komen Miami/Ft. Lauderdale is diverse in their backgrounds with multiple areas of expertise to be able to execute the various job requirements that are part of each job description. Most of the job descriptions were modified to reflect the talent and expertise of the individuals hired. In addition to the regular job responsibilities, staff members assist with manning booths at various community events on many nights and weekends to help build recognition of the local presence of Komen in the community. All staff members answer phones and have major responsibilities at every Affiliate event.

The staff currently consists of five full-time and one part-time employees. The Executive Director (full-time) is responsible for the total oversight of the Affiliate, including managing the staff, finance and budget, development of new revenue sources and having visibility in the community at large. The Executive Director is also currently the chair of the Komen Florida Public Policy Collaborative which consists of representatives from each of the six Komen Affiliates in the State of Florida. The Director of Development (full-time) is responsible for the oversight of all fundraising events and their logistics, as well as recruiting teams and individual participants. This position also has oversight of the Development Coordinator (full-time), whose primary responsibilities are to manage the administrative tasks needed for each event and assist with the logistics management during each event.

The Missions and Marketing Manager (full-time) oversees the entire grants process, managing 35 grantees and their contracts within the GeMS system, schedules and represents the Affiliate at community health fairs, writes grants for sponsorship/funding opportunities, and is responsible for completing the majority of the Community Profile. This position is also
responsible for the branding and marketing of all Affiliate materials and handles all social media and website needs. The Finance and Office Manager (full-time) handles the daily finance duties for the Affiliate, most tasks necessary for the smooth running of the office, as well as manages the volunteer base. The Affiliate Administrative Assistant (part-time) assists with answering phones, data processing and all administrative tasks as requested.

The Affiliate staff increased in 2014 with three of the current positions being new, but with a service area population of over 4.5 million residents, this growth needs to continue to be able to meet the increasing needs of the service community.

Susan G. Komen Miami/Ft. Lauderdale’s Board of Directors consists of professionals representing various industries throughout South Florida, such as banking, business, legal and real estate. Each term, the Board also includes a breast cancer survivor and/or someone whose life has been touched by breast cancer, such as a co-survivor. As the governing body for Komen Miami/Ft. Lauderdale, the Board’s responsibilities are multi-faceted: to ensure that the Affiliate and its programs are effectively meeting the needs of the community, to serve as ambassadors of Komen by increasing breast health awareness in the community, as well as to strategically plan ways to sustain and ultimately grow the Affiliate’s operations.

The Board of Directors currently has three active committees which support the Affiliate and its operations. These committees are Governance, Development and Finance. The Development Committee also serves as an important piece of the Race for the Cure Committee, with committee members playing a key role in the Race Operations.

The organizational structure for Komen Miami/Ft. Lauderdale is shown in Figure 1.1.

![Figure 1.1. Affiliate organizational structure](image)
**Affiliate Service Area**

The Komen Miami/Ft. Lauderdale service area consists of the three southernmost counties in the State of Florida; Broward, Miami-Dade and Monroe Counties. Miami-Dade County is the number one most populated county in Florida (population estimated at 2,617,176), with Broward County (population estimated at 1,838,844) ranked second. Monroe County (population estimated at 76,351) is unique in that its geographical layout is basically a chain of low lying islands connected to the mainland by U.S. Highway 1, which ends 150 miles south of Miami in Key West.

Broward County has a substantially higher Black/African-American female population (29 percent) than the other two counties in the Affiliate service area, with 51.3 percent of females over the age of forty. It has a slightly higher percentage of residents who are unemployed (10.5 percent), as well as 26.2 percent of the county’s population ages 40-64 with no health insurance. Broward is also home to three of the top four cities in Florida with the highest percentage of same sex couples per 1,000 households. Women who partner with women are believed to have a higher risk of breast cancer than other women because they usually have more risk factors. Transportation in Broward County may be an issue with no rail transportation except for a north/south tri-rail running through the east portion of the county and a poor bus system for the central and western parts of the county.

Miami-Dade County is home to the highest percentage (65 percent of the county’s female population) of Hispanic/Latina populations in Florida, with 49.7 percent of the female population over the age of forty. Miami-Dade County is in close proximity to Cuba, the Bahamas and the rest of the Caribbean Islands and as a result, has a significantly higher number (51.2 percent of the total population versus Broward at 31.2 percent and Monroe at 17.3 percent) of foreign born residents. With such a diverse population from so many different countries, the percentage of linguistically isolated population for Miami-Dade is a staggering 26.7 percent. This leads to many challenges for the Affiliate in this service area such as distributing educational materials in various languages and ensuring that the health care facilities have translators available as well as providing nurse navigators that can communicate with this very diverse population.

In addition to the language difficulties, there are many cultural issues in the ability to even discuss breast health issues with these discussions being perceived as taboo in many of the island cultures. Miami-Dade County has a large number of undocumented residents that are not believed to be included in any of the census population numbers as well as having the second highest rate of uninsured residents (34.4 percent) younger than 65. Transportation is fairly accessible with a county transportation system that includes bus and rail service throughout the county.

Monroe County’s geographical layout causes several unique issues in this part of the Affiliate service area. Key West is the southernmost point in the state and serves as the county seat. Being a small island located 150 miles from Miami with only one main highway in and out leads to transportation and service issues. This county has the largest female population in the three counties.
age demographic categories of 40 plus (59.8 percent), 50 plus (44.5 percent) and 65 plus (17.5 percent) of all three counties in the Affiliate service area. It also has a significantly higher percentage of residents designated as living in rural areas (8.7 percent versus 0.4 percent in Miami-Dade and 0.0 percent in Broward). Transportation may be an issue with no rail and minimal bus service throughout the county. While most of the Affiliate service area is easily reachable within an hour from the Affiliate office, this service area requires an overnight stay for most planned activities from the central part of Monroe County to Key West, leading to less in-person visits during the year and a more difficult time building meaningful relationships in this area. Komen Miami/Ft. Lauderdale's service area is shown in Figure 1.2.
Figure 1.2. Susan G. Komen Miami/Ft. Lauderdale service area
Purpose of the Community Profile Report

In order to ensure that Susan G. Komen Miami/Ft. Lauderdale is funding programs that address the specific unmet breast health needs of its community, the Affiliate works with local experts and community leaders to conduct a comprehensive needs assessment every four years, the Community Profile. The Community Profile strives to pinpoint populations most at risk of dying of breast cancer, identify needs and gaps, as well as assets, in the health system and understand what people know, think and do about breast cancer.

Ultimately, the Community Profile will allow the Affiliate to:

- Include a broad range of people and stakeholders in the Affiliate’s work and become more diverse
- Fund, educate and build awareness in the areas of greatest need
- Make data-driven decisions about how to use its resources in the best way to make the greatest impact.
- Strengthen relationships with sponsors by clearly communicating the breast health and breast cancer needs of the community
- Provide information to public policymakers to assist them in focusing their work
- Strategize the direction of marketing and outreach programs to ensure they are targeting the areas of greatest need
- Create synergy between Mission-related strategic plans and operational activities

Findings from the Community Profile will be instrumental in supporting the Affiliate’s strategic plan, defining specific strategies to address gaps and barriers to accessing services, and assessing the availability and quality of breast health services. The research in this report will not only direct future Affiliate grants funding, but also impact public policy initiatives, community mobilizing activities and the development of strong collaborations and partnerships throughout the service area.

Komen Miami/Ft. Lauderdale anticipates sharing the Community Profile with its extensive base of donors, volunteers, current and past grantees, county and state health departments, health care systems, community organizations, cancer collaborative and legislators in the service area. A PDF copy of the report will also be available on its website for easy downloading. By empowering the community with breast cancer knowledge and resources to take action, Komen Miami/Ft. Lauderdale ensures that those individuals most impacted by breast cancer – the uninsured and/or medically underserved – are not only reached, but adequately served.
Quantitative Data Report

Introduction

The purpose of the quantitative data report for Susan G. Komen® Miami/Ft. Lauderdale 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 Miami/Ft. Lauderdale’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

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Incidence Rates and Trends</th>
<th>Death Rates and Trends</th>
<th>Late-stage Rates and Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female Population (Annual Average)</td>
<td># of New Cases (Annual Average)</td>
<td>Age-adjusted Rate/100,000</td>
</tr>
<tr>
<td>US</td>
<td>154,540,194</td>
<td>182,234</td>
<td>122.1</td>
</tr>
<tr>
<td>HP2020</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Florida</td>
<td>9,457,566</td>
<td>13,724</td>
<td>114.3</td>
</tr>
<tr>
<td>Komen Miami/Ft. Lauderdale Service Area</td>
<td>2,189,774</td>
<td>2,848</td>
<td>111.2</td>
</tr>
<tr>
<td>White</td>
<td>1,613,451</td>
<td>2,273</td>
<td>111.0</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>511,015</td>
<td>474</td>
<td>102.4</td>
</tr>
<tr>
<td>American Indian/Alaska Native (AIAN)</td>
<td>7,484</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>Asian Pacific Islander (API)</td>
<td>57,823</td>
<td>26</td>
<td>46.3</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>1,156,555</td>
<td>1,670</td>
<td>121.7</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>1,033,219</td>
<td>1,178</td>
<td>99.4</td>
</tr>
<tr>
<td>Broward County - FL</td>
<td>893,482</td>
<td>1,258</td>
<td>119.1</td>
</tr>
<tr>
<td>Miami-Dade County - FL</td>
<td>1,262,184</td>
<td>1,537</td>
<td>105.3</td>
</tr>
<tr>
<td>Monroe County - FL</td>
<td>34,107</td>
<td>53</td>
<td>108.5</td>
</tr>
</tbody>
</table>

*Target as of the writing of this report.  
SN – data suppressed due to small numbers (15 cases or fewer for the 5-year data period).  
NA – data not available  
Rates are in cases or deaths per 100,000.  
Age-adjusted rates are adjusted to the 2000 US standard population.  
Source of death rate data: Centers for Disease Control and Prevention (CDC) – National Center for Health Statistics (NCHS) death data in SEER*Stat.  
Source of death trend data: National Cancer Institute (NCI)/CDC State Cancer Profiles.

**Incidence rates and trends summary**  
Overall, the breast cancer incidence rate and trend in the Komen Miami/Ft. Lauderdale service area were lower than that observed in the US as a whole. The incidence rate of the Affiliate service area was significantly lower than that observed for the State of Florida and the incidence trend was not significantly different than the State of Florida.

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.

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

The incidence rate was significantly lower in the following county:
- Miami-Dade County

The remaining county (Monroe County) had an incidence rate and trend that were not significantly different than the Affiliate service area as a whole. 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 Miami/Ft. Lauderdale service area was slightly lower than that observed in the US as a whole and the death rate trend was not available for comparison with the US as a whole. The death rate of the Affiliate service area was not significantly different than that observed for the State of Florida.

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.

The following county had a significantly more favorable breast cancer death rate trend than the Affiliate service area as a whole:
- Miami-Dade County

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

**Late-stage incidence rates and trends summary**
Overall, the breast cancer late-stage incidence rate and trend in the Komen Miami/Ft. Lauderdale service area were similar to that observed in the US as a whole. The late-stage
The incidence rate of the Affiliate service area was **significantly higher** than that observed for the State of Florida and the late-stage incidence trend was not significantly different than the State of Florida.

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

The late-stage incidence rate was significantly lower in the following county:
- Monroe County

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

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

*As of October 2015

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

The data have been weighted to account for differences between the women who were interviewed and all the women in the area. For example, if 20.0 percent of the women interviewed are 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>
<thead>
<tr>
<th>Population Group</th>
<th># of Women Interviewed (Sample Size)</th>
<th># w/ Self-Reported Mammogram</th>
<th>Proportion Screened (Weighted Average)</th>
<th>Confidence Interval of Proportion Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>174,796</td>
<td>133,399</td>
<td>77.5%</td>
<td>77.2%-77.7%</td>
</tr>
<tr>
<td>Florida</td>
<td>3,120</td>
<td>2,374</td>
<td>76.6%</td>
<td>74.6%-78.4%</td>
</tr>
<tr>
<td>Komen Miami/Ft. Lauderdale Service Area</td>
<td>461</td>
<td>371</td>
<td>79.0%</td>
<td>73.9%-83.4%</td>
</tr>
<tr>
<td>White</td>
<td>350</td>
<td>278</td>
<td>79.2%</td>
<td>73.4%-84.0%</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>78</td>
<td>64</td>
<td>77.6%</td>
<td>61.7%-88.2%</td>
</tr>
<tr>
<td>AIAN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
<tr>
<td>API</td>
<td>11</td>
<td>9</td>
<td>83.0%</td>
<td>47.8%-96.3%</td>
</tr>
<tr>
<td>Hispanic/ Latina</td>
<td>155</td>
<td>124</td>
<td>77.9%</td>
<td>68.8%-85.0%</td>
</tr>
<tr>
<td>Non-Hispanic/ Latina</td>
<td>303</td>
<td>246</td>
<td>80.1%</td>
<td>73.7%-85.3%</td>
</tr>
<tr>
<td>Broward County - FL</td>
<td>199</td>
<td>165</td>
<td>79.8%</td>
<td>71.8%-86.0%</td>
</tr>
<tr>
<td>Miami-Dade County - FL</td>
<td>254</td>
<td>200</td>
<td>78.3%</td>
<td>71.1%-84.0%</td>
</tr>
<tr>
<td>Monroe County - FL</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
<td>SN</td>
</tr>
</tbody>
</table>

SN – data suppressed due to small numbers (fewer than 10 samples).
Data are for 2012.
Source: CDC – Behavioral Risk Factor Surveillance System (BRFSS).

**Breast cancer screening proportions summary**

The breast cancer screening proportion in the Komen Miami/Ft. Lauderdale 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 Florida.

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

<table>
<thead>
<tr>
<th>Population Group</th>
<th>White</th>
<th>Black/African-American</th>
<th>AIAN</th>
<th>API</th>
<th>Non-Hispanic/Latina</th>
<th>Hispanic/Latina</th>
<th>Female Age 40 Plus</th>
<th>Female Age 50 Plus</th>
<th>Female Age 65 Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>78.8%</td>
<td>14.1%</td>
<td>1.4%</td>
<td>5.8%</td>
<td>83.8%</td>
<td>16.2%</td>
<td>48.3%</td>
<td>34.5%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Florida</td>
<td>79.1%</td>
<td>17.3%</td>
<td>0.5%</td>
<td>3.1%</td>
<td>77.4%</td>
<td>22.6%</td>
<td>53.2%</td>
<td>39.6%</td>
<td>19.1%</td>
</tr>
<tr>
<td>Komen Miami/Ft. Lauderdale</td>
<td>73.4%</td>
<td>23.4%</td>
<td>0.4%</td>
<td>2.8%</td>
<td>51.5%</td>
<td>48.5%</td>
<td>50.5%</td>
<td>35.4%</td>
<td>16.1%</td>
</tr>
<tr>
<td>Service Area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broward County - FL</td>
<td>66.6%</td>
<td>29.0%</td>
<td>0.4%</td>
<td>4.0%</td>
<td>74.2%</td>
<td>25.8%</td>
<td>51.3%</td>
<td>35.9%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Miami-Dade County - FL</td>
<td>77.8%</td>
<td>20.0%</td>
<td>0.3%</td>
<td>1.9%</td>
<td>35.0%</td>
<td>65.0%</td>
<td>49.7%</td>
<td>34.8%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Monroe County - FL</td>
<td>91.2%</td>
<td>6.6%</td>
<td>0.5%</td>
<td>1.7%</td>
<td>78.9%</td>
<td>21.1%</td>
<td>59.8%</td>
<td>44.5%</td>
<td>17.5%</td>
</tr>
</tbody>
</table>

Data are for 2011.
Data are in the percentage of women in the population.
Source: US Census Bureau – Population Estimates
Table 2.5. Population characteristics – socioeconomics

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Less than HS Education</th>
<th>Income Below 100% Poverty</th>
<th>Income Below 250% Poverty (Age: 40-64)</th>
<th>Unemployed</th>
<th>Foreign Born</th>
<th>Linguistically Isolated</th>
<th>In Rural Areas</th>
<th>In Medically Underserved Areas</th>
<th>No Health Insurance (Age: 40-64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>14.6 %</td>
<td>14.3 %</td>
<td>33.3 %</td>
<td>8.7 %</td>
<td>12.8 %</td>
<td>4.7 %</td>
<td>19.3 %</td>
<td>23.3 %</td>
<td>16.6 %</td>
</tr>
<tr>
<td>Florida</td>
<td>14.5 %</td>
<td>14.7 %</td>
<td>39.0 %</td>
<td>10.3 %</td>
<td>19.2 %</td>
<td>7.1 %</td>
<td>8.8 %</td>
<td>7.5 %</td>
<td>24.2 %</td>
</tr>
<tr>
<td>Komen Miami/Ft. Lauderdale Service Area</td>
<td>18.2 %</td>
<td>15.8 %</td>
<td>44.1 %</td>
<td>10.1 %</td>
<td>42.5 %</td>
<td>18.3 %</td>
<td>0.4 %</td>
<td>6.8 %</td>
<td>32.6 %</td>
</tr>
<tr>
<td>Broward County - FL</td>
<td>12.7 %</td>
<td>13.0 %</td>
<td>36.7 %</td>
<td>10.5 %</td>
<td>31.2 %</td>
<td>8.5 %</td>
<td>0.0 %</td>
<td>0.0 %</td>
<td>26.2 %</td>
</tr>
<tr>
<td>Miami-Dade County - FL</td>
<td>22.4 %</td>
<td>17.9 %</td>
<td>49.9 %</td>
<td>9.9 %</td>
<td>51.2 %</td>
<td>26.7 %</td>
<td>0.4 %</td>
<td>8.9 %</td>
<td>37.5 %</td>
</tr>
<tr>
<td>Monroe County - FL</td>
<td>10.7 %</td>
<td>11.6 %</td>
<td>34.7 %</td>
<td>6.1 %</td>
<td>17.3 %</td>
<td>5.4 %</td>
<td>8.7 %</td>
<td>100.0 %</td>
<td>24.5 %</td>
</tr>
</tbody>
</table>

Data are in the percentage of people (men and women) in the population.
Source of health insurance data: US Census Bureau – Small Area Health Insurance Estimates (SAHIE) for 2011.
Source of medically underserved data: Health Resources and Services Administration (HRSA) for 2013.
Source of other data: US Census Bureau – American Community Survey (ACS) for 2007-2011.

Population characteristics summary
Proportionately, the Komen Miami/Ft. Lauderdale service area has a substantially smaller White female population than the US as a whole, a substantially larger Black/African-American female population, a slightly smaller Asian and Pacific Islander (API) female population, a slightly smaller American Indian and Alaska Native (AIAN) female population, and a substantially larger Hispanic/Latina female population. The Affiliate’s female population is slightly older than that of the US as a whole. The Affiliate’s education level is slightly lower than and income level is slightly lower than those of the US as a whole. There 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 substantially larger percentage of people without health insurance, and a substantially smaller percentage of people living in medically underserved areas.

The following county has a substantially larger Black/African-American female population percentage than that of the Affiliate service area as a whole:
- Broward County

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

The county with a substantial foreign born and linguistically isolated population is:
- Miami-Dade County
Priority Areas

Healthy People 2020 forecasts

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

HP2020 has several cancer-related objectives, including:

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

To see how well counties in the Komen Miami/Ft. Lauderdale service area are progressing toward these targets, the report uses the following information:

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

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

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

Identification of priority areas

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

Late-stage incidence reflects both the overall breast cancer incidence rate in the population and the mammography screening coverage. The breast cancer death rate reflects the access to care and the quality of care in the health care delivery area, as well as cancer stage at diagnosis.
There has not been any indication that either one of the two HP2020 targets is more important than the other. Therefore, the report considers them equally important.

Counties are classified as follows (Table 2.6):
- Counties that are not likely to achieve either of the HP2020 targets are considered to have the highest needs.
- Counties that have already achieved both targets are considered to have the lowest needs.
- Other counties are classified based on the number of years needed to achieve the two targets.

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

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

If the time to achieve a target cannot be calculated for one of the HP2020 indicators, then the county is classified based on the other indicator. If both indicators are missing, then the county is not classified. This 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 Miami/Ft. Lauderdale service area with predicted time to achieve the HP2020 breast cancer targets and key population characteristics

<table>
<thead>
<tr>
<th>County</th>
<th>Priority</th>
<th>Predicted Time to Achieve Death Rate Target</th>
<th>Predicted Time to Achieve Late-stage Incidence Target</th>
<th>Key Population Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broward County - FL</td>
<td>Medium High</td>
<td>4 years</td>
<td>13 years or longer</td>
<td>%Black/African-American</td>
</tr>
<tr>
<td>Monroe County - FL</td>
<td>Medium</td>
<td>13 years or longer</td>
<td>Currently meets target</td>
<td>Rural, medically underserved</td>
</tr>
<tr>
<td>Miami-Dade County - FL</td>
<td>Low</td>
<td>Currently meets target</td>
<td>2 years</td>
<td>%Hispanic/Latina, foreign, language</td>
</tr>
</tbody>
</table>

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

**Map of Intervention Priority Areas**

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

![Figure 2.1. Intervention priorities](image-url)
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

*Medium high priority areas*
One county in the Komen Miami/Ft. Lauderdale service area is in the medium high priority category. Broward County is not likely to meet the late-stage incidence rate HP2020 target. The incidence rates in Broward County (119.1 per 100,000) are significantly higher than the Affiliate service area as a whole (111.2 per 100,000). The late-stage incidence trends in Broward County (1.4 percent per year) indicate that late-stage incidence rates may be increasing. Broward County has a relatively large Black/African-American population.

*Medium priority areas*
One county in the Komen Miami/Ft. Lauderdale service area is in the medium priority category. Monroe County is not likely to meet the death rate HP2020 target. Although not significantly different from the affiliate as a whole, incidence trends in Monroe County (11.7 percent per year) indicate that incidence rates are increasing. The death rates in Monroe County (25.1 per 100,000) appear to be higher than the Affiliate service area as a whole (21.1 per 100,000) although not significantly. The late-stage incidence trends in Monroe County (0.5 percent per year) indicate that late-stage incidence rates may be increasing. In Monroe County a relatively large proportion of the population is living in rural and medically underserved areas.
Selection of Target Communities

Susan G. Komen Miami / Ft. Lauderdale has chosen four target communities within its service area. The Affiliate will continue to focus efforts on these four communities over the course of the next four years to ensure that the Affiliate is doing everything possible to meet the target goals of Healthy People 2020 for breast cancer.

When selecting these four 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 Susan G. Komen Miami / Ft. Lauderdale’s commitment to the community, the Affiliate analyzed the current statistics provided and how best to meet goals of the Healthy People 2020 for this service area. Through this review, the 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 communities included but were not limited to:

- Incidence rates and trends
- Death rates and trends
- Late-stage rates and trends
- Income below poverty levels (both 100 percent and 250 percent age 40-64 categories)
- Linguistically isolated population
- Residents without health insurance
- Medically underserved areas
- Population demographics of service area

While none of the counties in the service area have a combined Highest or High Needs priority classification based on the projected time to achieve Healthy People 2020 breast cancer targets (Table 2.7), two of these communities do have a highest rating of thirteen years or longer, on one of the components of the Healthy People 2020 breast cancer targets.

The selected target communities are:

- Broward County: Black/African-American females and women who partner with women
- Monroe County
- Miami/Dade County: Women who are linguistically isolated/foreign born

Broward County, Florida

Broward County has a Medium High Needs / priority classification based on the projected time of 13 years or longer to meet the Healthy People 2020 target goal for late-stage incidence and 0-6 years to meet the death rate target goal.

As stated in Table 2.1, the overall Incidence rates and trends for Broward County are an age-adjusted rate of 119.1 per 100,000 with an increasing trend of 0.7 percent. This rate is significantly higher than the Affiliate service area as a whole (111.2 per 100,000). The Broward County late-stage rate is 45.1 which is currently 4.1 over the Healthy People 2020 target goal of 41.0 with a trend of 1.4 percent indicating that late-stage incidence rates may be increasing.
This county has a slightly higher percentage of residents who are unemployed. While the percentages of foreign born and linguistically isolated residents are slightly lower than the Affiliate service area, they are still higher than the United States averages. While the Affiliate service area as a whole has a substantially higher percentage of the population age 40-64 living without health insurance (32.6 percent), Broward County has a substantially larger percentage of this population without health insurance than the United States average of 16.6 percent.

Broward County has a substantially higher Black/African-American female population than the other two counties in the service area. This is important to note because of the breast cancer disparities that exist between Black/African-American women and women of other Races. In the Affiliate service area, Black/African-American women have a death rate of 29.0 per 100,000 women compared to 19.6 per 100,000 for White women. Similarly, the late-stage rate for Black/African-American women in the Affiliate service area is 48.1 per 100,000 compared to 42.0 for White women.

Data is limited on women who partner with women; however, according to the Williams Institute Florida Census Snapshot of 2010, Broward County ranks number two in the state in same sex couples with an estimated 11.33 per 1,000 households. Broward County also has three out of the top four cities in the state rankings of highest percentage of same sex couples per 1,000 households. Women who partner with women are believed to have more risk factors for breast cancer than other women. They are less likely to bear children or to have children earlier in life. Obesity and alcohol use rates are also higher among women who partner with women.

**Monroe County, Florida**

Monroe County is the southernmost county in Florida and the United States. It is 73 percent water and comprised of the Florida Keys and portions of both Everglades National Park and Big Cypress National Preserve. The most well-known part of Monroe County is the Florida Keys, a chain of low lying islands connected to the mainland by U.S. Highway 1, which ends 150 miles south of Miami in Key West. Since most of Monroe County only has one highway, access to the county seat in Key West is difficult. Due to the geographical layout of Monroe County medical access is limited with 100 percent of the population listed as living in medically underserved areas and 8.7 percent in rural areas per Table 5. The female population of Monroe County is substantially older than the United States average in both the categories of 40 plus (59.8 percent vs. 48.3 percent) and 50 plus (44.5 percent vs. 34.5 percent) with a slight increase in average for the 65 plus category (17.5 percent vs. 14.8 percent).

Monroe County has a Medium Needs / priority classification based on the projected time of 13 years or longer to meet the Healthy People 2020 death rate target goal while it currently meets the Healthy People 2020 late-stage incidence target goal. Monroe County has a death rate of 25.1 per 100,000 which is substantially higher than the Healthy People 2020 rate of 20.6 per 100,000 as well as the Komen Miami / Ft. Lauderdale service area rate of 21.1 per 100,000.

While the female breast cancer incidence rates and trends listed in Table 2.1 indicate that Monroe County currently has a lower incidence rate at 108.5 per 100,000 than the National rate
of 122.1 per 100,000 or even the Affiliate average rate of 111.2 per 100,000, the incidence trend shows an 11.7 percent annual percentage change. The late-stage rates and trends listed in Table 2.1 also show Monroe County having a significantly lower late-stage age-adjusted rate of 32.7 per 100,000 vs. the National average of 43.8.

The data were suppressed due to small numbers (fewer than 10 samples) on the proportion of women ages 50-74 with screening mammography in the last two years who self-reported in Monroe County.

**Miami-Dade County**

Miami-Dade County is the most populous county in the Komen Miami / Ft. Lauderdale service area hosting over half of the service area population. Miami-Dade County currently meets the Healthy People 2020 breast cancer death rate target and was projected to meet the late-stage incidence target goal in two years. The incidence rate of 105.3 per 100,000 is the lowest in the Affiliate service area and is trending at -2.6 percent.

The demographics of Miami-Dade County per Table 2.4 show that 65.0 percent of the residents are Hispanic/Latina (vs. the national average of 16.2 percent), with 51.2 percent being foreign born (vs. 12.8 percent nationally) and 26.7 percent being linguistically isolated (vs. 4.7 percent nationally). There is a substantially higher percentage of residents who are living with no health insurance (age 40-64) with Miami-Dade County having 37.5 percent vs. the national average of 16.6 percent and the State of Florida average of 24.2 percent. Also, 49.9 percent of the residents age 40-64 have an income below 250 percent poverty as listed in Table 2.5.

With 51.2 percent of the Miami-Dade County population being foreign born and 26.7 percent being linguistically isolated it is imperative that Komen Miami / Ft. Lauderdale continue to search for ways to impart breast health information and materials that communicate in the various languages and learning styles of this demographic and to ensure that these different methods result in a continued improvement in the Healthy People 2020 Breast Cancer Initiative.
Health Systems Analysis Data Sources

Resources
Komen Miami/Ft. Lauderdale used a multi-method approach in its health systems analysis that allowed for the collection of data to construct its health system profile for Broward, Miami-Dade, and Monroe Counties. In a span of 45 days, a team of six volunteers were able to review websites and organizational reports and later interview a sample of key personnel drawn from among the 275 organizations that serve this region.

Methods
The volunteers began with the resources suggested by the Headquarters Community Profile Team. Those resources included: all mammography facilities certified by the Food & Drug Administration, hospitals registered with Medicare, local health departments; various community health centers classified as FQHCs, FQHC look-alikes, and outpatient health programs operated by tribal organizations; and the various safety-net health care organizations that are classified as 501 (c)(3) entities. In conjunction with the work being done by the volunteers, staff within the Affiliate independently worked with members of its network to verify the comprehensiveness of the information obtained through these resources. In doing so, the Affiliate collaborated with contacts at the Department of Health in Broward and Miami-Dade Counties to add an estimated 25 additional clinics and health centers. In all three counties, the volunteers identified additional sites or resources during their initial review of the websites and these entities were added to the master file.

A systematic process was followed by the Affiliate to extract data from the five resources as part of the health systems analysis. The process consisted of two primary steps. The first was to identify all of the providers and organizations that fell within the region of this Affiliate by county or corresponding ZIP code. The volunteers then went to the websites of each provider/organization extracting information as responsive to the health systems template. If sufficient information was not obtained via the website, volunteers then called each resource, using a standardized interview guide developed by the Affiliate, to obtain missing information. After these two steps were completed, a team appointed by the Affiliate Executive Director reviewed the complete spreadsheet and conducted a gap analysis of this information.

Analytical Plan
The Affiliate approached the Systems Analysis with the intent to accomplish the following two objectives:

1. List the strengths and weaknesses that exist in the health systems related to service delivery.
2. Identify by county where deficiencies and gaps exist so that the Affiliate can establish new partnerships in the community to address these needs.

These objectives have guided the analysis and subsequent conclusions made about the information collected.
Completion of the first objective is guided by a macro-level assessment of the strength of each county and the overall region to support a comprehensive, efficient and effective continuum of care. Using the Komen Headquarters template, the Executive Director reviewed the full listing of programs and services to first assess that within each county a combination of all of the services are provided at a local level. The Executive Director then returned to the geographical dispersion of these services to assess the convenience and accessibility of these services within the neighborhoods. Finally, she reviewed the balance of the services across the counties to make sure that in some areas men and women are not isolated from these services and that the various options in services, at a minimum, meet the accepted standards for an effectively modeled continuum. The strength of the continuum is determined by:

- Does the county in some equitable manner offer the services listed in the template?
- Are the services reasonably dispersed or concentrated in one part of the county/region?
- Do these reach the intended populations and sub-populations within the counties?
- Are the services dynamic, offering a varied combination of services, or narrow in their options within the county/region?

Each county will receive a rating of strong or weak as determined by the number of affirmative responses they receive on the template. Successful completion of the second objective is the analysis of the collective set of information. Objective 1 enabled the Affiliate to list the available resources, describe the dispersion of these resources across or within the three counties, and illuminate the duplication of services/resources or deficiencies in the supply of resources in the region. Objective 2 requires the Executive Director to focus on gaps in services and articulate potential need for shifting and allocation of support across the region by the Affiliate to improve screening, treatment and support with the focus of equity in the availability and corresponding allocation of resources among the region and efficiency in the provision of services. The Executive Director reviewed both the dispersion map and the rating of strong or weak side-by-side to comprehend the gaps that exist in support, resources and services; and the capacity of the 275 organizations to support or fill these gaps within and across the counties.

**Health Systems Overview**

**Continuum of Care**
The Concept of the Continuum of Care (CoC) is one where, through an integrated system of care, persons are guided through a comprehensive array of health services over a period of time (Figure 3.1). The goal is to meet the specific needs of patients at all phases of the continuum, from screening to diagnosis to, if applicable, the end of life. As it relates to breast cancer, the Continuum of Care takes patients from being screened for breast cancer, to receiving the necessary diagnostic care if an abnormality is found, to getting treatment if breast cancer is diagnosed, and finally, receiving follow-up care during and after treatment. Ideally, a patient would move through the CoC quickly and seamlessly, receiving quality care in a timely fashion in order to have the best outcomes. One can see that education plays an important role throughout the entire CoC.
Figure 3.1. Breast Cancer Continuum of Care (CoC)

**Screening:** Technically, a person can enter the CoC at any point; however, breast cancer screenings are most often the point of entry into the continuum. Screening tests can include: Clinical Breast Exams (CBE) and screening mammograms. Screening tests can detect breast cancer early, when the chances of survival are the highest. Thus, getting screened regularly for breast cancer is the best way for women to lower their risk of dying from the disease. If the screening results are normal, the patient would not need to continue on in the CoC, but rather loop back into follow-up care when he/she is due for his/her next screening. Education plays a critical role at this phase of the continuum, oftentimes encouraging women to get screened and reinforcing the need to continue to get screened regularly from that point on.

**Diagnosis:** If a CBE or screening mammogram detects an abnormality, the patient will be referred for follow-up diagnostic testing. Diagnostic testing often begins with the least invasive tests, such as a diagnostic mammogram or ultrasound. A radiologist will look at the images from these tests and decide whether the abnormal finding is suspicious. In some cases, the health care provider may request a breast MRI and/or a biopsy. If the findings are benign (not cancer), patients return to their regular schedule of screening with clinical breast exams and mammograms. Sometimes after an abnormal result, even if breast cancer is not detected, health care professionals will recommend shorter intervals for subsequent screenings. Recommended intervals may range from 3-6 months for some patients to the standard 12 months for most women. At this point in the CoC, education comes in the form of communicating the importance of proactively seeking out test results, keeping follow-up appointments and understanding what the results mean so as to minimize anxiety and fear.

**Treatment:** If the patient receives a breast cancer diagnosis, he/she will enter the treatment phase of the Continuum of Care. Patients will work with their health care provider to determine the best treatment plan. Standard breast cancer treatments can include: chemotherapy, radiation therapy, surgery, reconstruction, etc. The length of treatment varies from patient to patient. For some, it may last a few months, while for others it may last years. Education during
the treatment phase includes such topics as treatment options, the role of pathology reports in determining the best course of treatment, side effect management, etc.

**Follow-up Care:** While the CoC model shows follow-up and survivorship coming upon completion of treatment, oftentimes they occur simultaneously. Follow-up and survivorship may include supportive services such as navigating insurance issues, exercise and nutrition programs, financial assistance, symptom management, support groups, individual counseling, complementary therapies and long-term care. During the follow-up phase, health care providers will also recommend a schedule for regular screening tests and follow-up visits in an effort to keep track of the patient’s recovery and quality of life, and, if cancer returns, detect it early. Education at this phase in the continuum may include topics such as making healthy lifestyle choices, long-term effects of treatment, side effect management and the importance of follow-up care.

Komen Miami/Ft. Lauderdale understands that delays in the Continuum of Care exist. Undoubtedly, these delays, whether at the point of follow-up after an abnormal screening, at the start of treatment or even when completing treatment, can result in poor outcomes for the breast cancer patient. As a result, the Continuum of Care model is utilized to guide the Affiliate through:

- assessing and understanding why some patients delay entry into the continuum, or never enter at all
- finding gaps in service availability
- identifying barriers faced, such as lack of transportation, language barriers, fear, system issues such as long waits for appointments, lack of knowledge

Education plays an important role in not only addressing some of these barriers, but in helping patients move through the Continuum of Care more quickly.

**Summary of findings - Susan G. Komen Miami/Ft. Lauderdale Target Communities**

Susan G. Komen Miami/Ft. Lauderdale service area encompasses three counties. Miami-Dade County is the most populous county in the State of Florida with approximately 2.5 million residents and ranks as the seventh most populous county in the United States. Broward County is the second most populous county in Florida with over 1.7 million residents and ranks eighteenth in the United States. Monroe County, with only 73,090 residents, has 87 percent of its land mass on the mainland, but that area is predominately Florida Everglades and is virtually uninhabited. Over 99 percent of Monroe County residents live in the Florida Keys. Komen Miami/Ft. Lauderdale identified four priority target communities based on the quantitative data results for the service area. After reviewing the Health Systems Analysis template, the following summaries outline the strengths and weaknesses of each priority community.

**Broward County – Black/African-American Females**

One of the strengths of the health systems located within this county is the number and locations of the hospital systems (Figure 3.2). Broward County has 17 hospitals, spread fairly evenly throughout the county. Most of these hospitals provide full continuum of care services
and combined with the other breast health resources available appear to adequately serve most communities within the county. Their geographic location in or near many of the underserved communities is a strength. With a substantially higher Black/African-American Female population (29.0 percent versus 14.1 percent nationally or 17.3 percent Statewide) and late-stage diagnosis trending upward at 1.4 percent, providing more treatment and support/survivorship services is a priority for this community. There are only four free clinics listed, however, most of the hospitals provide for free or reduced services. Several of the hospitals located in or near the underserved communities are lacking patient navigation services which would help ensure that this population is being provided adequate services and follow up.

Komen Miami/Ft. Lauderdale currently partners with 23 grantees that serve Broward County including the Broward County Health Department, Gilda’s Club, Women’s Breast Health Initiative, Project Access, Planned Parenthood of South Florida as well as 12 of the 17 hospitals in the county. Several of these grantees focus primarily on the priority target population for this county.

There are several hospitals and breast health service providers that are currently not grantees or partners that have been targeted based on the services needed for the priority community. Broward AHEC, The Links (Broward Chapter) and three of the hospital systems that are located in predominately underserved areas are potential partners that would help ensure that the needs of this community are met.

**Broward County – Women who partner with women**

Broward County is home to three of the top four cities in the state rankings of highest percentage of same sex couples per 1,000 households (Sun Sentinel, 2011). Two of these cities have hospitals located in the city and the third has one within a five minute drive. Geographically, the support systems are in place. The bigger question is are these health systems welcoming and trained in diversity for this population. Komen Miami/Ft. Lauderdale needs to look closer at how this population is being served and any issues that might prevent adequate health system services.

Currently, there is no grantee that partners with this community, however the Affiliate is in discussions with The Pride Center in Broward County to partner on training to increase the cultural sensitivity of health care providers in the service area. The Affiliate continues to do research on various groups that it can partner with going forward to make sure that this demographic is being adequately served.

**Miami-Dade County – Women who are linguistically isolated/foreign born**

Miami-Dade County has a female Hispanic/Latina population of 65.0 percent with 51.2 percent of the overall population being foreign born and 26.7 percent linguistically isolated. With 20 hospitals that are geographically spread throughout the county, most are within a short car or bus ride for services (Figure 3.3). There are also 20 free clinics which is important in serving this demographic. Many of these clinics speak multiple languages based on their location and help serve a population that isn’t accustomed to the health care industry in America. Most of
the hospitals employ multilingual employees so that they can service the needs of this varied demographic. Komen Miami/Ft. Lauderdale provides materials in Spanish, but has requested Komen materials be translated and printed in Creole so that the Haitian population can be better served. One of the bigger barriers to this population is educating them on the importance of early detection and that talking about breast health is important. Many come from places where discussing the female body is taboo and don't engage in preventive health services.

Komen Miami/Ft. Lauderdale has 25 grantees that serve the Miami-Dade area. Most of these are at the least bi-lingual and many are tri-lingual as needed in this service area. Several focus on education and services for this target demographic including Miami-Dade AHEC, Community Life Support, Inc., Project Access Foundation, Inc. and Liga Contra el Cancer, Inc. Komen Miami/Ft. Lauderdale currently partners with 11 of the 20 hospitals listed and 15 of the 20 free clinics. The Affiliate is fortunate that it has a research facility in its service area that is a partner both on the local level as well as through Komen Headquarters. There are several hospitals that are in the process of building new cancer institutes that the Affiliate has started discussions on ways to partner in the future. The Affiliate has targeted two of the hospitals on the eastern side of the county that it has never partnered with as well as several smaller community organizations that focus primarily on serving the target demographic.

**Monroe County – Female population**

With the population of Monroe County located in the Florida Keys, easy access to health care services is limited (Figure 3.4). The Keys are broken up into three segments, the Upper Keys (Tavernier area), the Middle Keys (Marathon area) and the Lower Keys (Key West area). These areas are all situated along a single highway that runs through the Keys to Key West. There are three hospitals, one serving each geographical segment of the Florida Keys. There are four free clinics, but these are all located in Key West, which could be up to a three hour drive for residents of the Upper Keys. Providing easy access to the full continuum of care is of major concern to the Affiliate.

Komen Miami/Ft. Lauderdale has partnered through its grants program with two grantees in the Florida Keys, WomenKind in Key West and Florida Keys AHEC in Marathon in the Middle Keys. The Affiliate is actively looking at how it can help increase services and provide easier access, as well as other partnership opportunities. Not only is the Affiliate looking at health service organizations in the Keys for future partnerships, it is actively looking to host more Affiliate activities in this area to ensure that it is always providing services and awareness in this remote area. The Affiliate has not partnered directly with the hospitals in the three segment locations of the Keys and hopes that it can find a way to help provide more services and better access to this demographic.
Figure 3.2. Breast cancer services available in Broward County
Figure 3.3. Breast cancer services available in Miami-Dade County
Figure 3.4. Breast cancer services available in Monroe County
Public Policy Overview

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)
All women are at risk for breast and cervical cancer, but regular screenings can prevent or detect these diseases early. The National Breast and Cervical Cancer Early Detection Program (NBCCEDP, pronounced “National B-cep”) was created in response to the Breast and Cervical Cancer Death Prevention Act passed by Congress in 1990 (Public Law 101-354). The Act established a program of cooperative agreements with states, tribes, and territories to increase the early detection and prevention of breast and cervical cancer among low-income, uninsured women.

The Act specified that the program be administered by the Centers for Disease Control and Prevention (CDC) to provide clients with physical examinations of the breasts, mammograms, pelvic examinations, and Pap tests by a qualified health care professional. Other services include Human papillomavirus (HPV) tests, diagnostic testing for abnormal results, and referrals for treatment.

NBCCEDP tries to reach as many women in medically underserved communities as possible, including older women, women who are recent immigrants, and women who are members of racial and ethnic minorities. Screening services are mainly offered through non-profit organizations, hospitals, and local health clinics. Through these NBCCEDP partners, women without health insurance, or those with insurance that does not cover these tests, can get breast and cervical cancer testing for free or at very low cost.

Since 1991, NBCCEDP has provided more than 10.7 million screening exams for breast and cervical cancer to underserved women; diagnosed more than 56,662 breast cancers; found about 152,470 pre-cancerous cervical lesions; and diagnosed over 3,206 cervical cancers nationwide (American Cancer Society, 2013).

The CDC provides funds and support for each state-administered program. In 1994, the Florida Department of Health received a federal grant from the CDC to establish the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP, pronounced “Florida B-cep”). The program is also often referred to as the Mary Brogan Breast and Cervical Cancer Early Detection Program Act.

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP), including the FBCCEDP, focuses on the following four areas to improve preventive screening in underserved women:

- Provide public education and outreach to help women in underserved communities understand and navigate the health care system;
- Screen women who are not yet covered by the ACA, with a focus on states that do not expand Medicaid, like Florida;
- Provide quality care and assuring follow-up for women diagnosed with breast and cervical cancer through participation in the FBCCEDP; and
• Play a key role in the development of unified and organized continuum of care health systems.

FBCCEDP provides breast and cervical cancer screenings to eligible women. In order to be eligible for FBCCEDP, the following criteria must be met by applicants:

• Female;
• Between the ages 50-64;
• Household income is less than or equal to 200 percent of the Federal Poverty Level (Appendix A);
• Uninsured;
• Has no health insurance which will cover the cost of a Clinical Breast Exam (CBE), mammogram, or Pap smear

The 2012-2013 Fiscal Year was the first time the State of Florida contributed state general revenue to FBCCEDP. The $1,236,473 contributed was a partial match to the federal dollars allocated. Yet, and yet, even with the additional state funding received these past two years, FBCCEDP is only able to serve 5.4 percent of the targeted population of low-income, no insurance or underinsured women ages 50 to 64 years. This equates to just 13,668 women, leaving 94.6 percent, or 250,726 eligible women who need these lifesaving screenings, unable to access the program due to its funding limitations (M. Bowers, personal communication, June 27, 2014).

FBCCEDP is administered by the Florida Department of Health. Although there are 67 counties in the state of Florida, the program is coordinated through 16 lead county health departments. Regional coordinators manage service provision in their assigned counties across the state to assure statewide access to the program. The previously mentioned services provided by the national program (physical examinations of the breasts, mammograms, pelvic examinations, etc.) are also provided by FBCCEDP. Women screened through FBCCEDP who are diagnosed with breast and/or cervical cancer may be eligible for treatment through the Mary Brogan Medicaid Treatment Act. Additional FBCCEDP service goals include outreach, public education and professional education, focusing on high late-stage cancer rates.

FBCCEDP is noted to be Option One under the Medicaid Treatment Act, meaning a patient must initiate care with the program. If a screening is done outside of the program, the patient cannot use the benefits that the program has to offer to patients who do their screening there. Knowledge and education about the program are not common in the Affiliate area, causing many women to be disqualified. When used properly, the program saves lives and offers a full continuum of care.

The 16 lead counties are: Brevard, Broward, Duval, Escambia, Gadsden, Hillsborough, Jackson, Leon, Manatee, Miami-Dade, Osceola, Pasco, Pinellas, Putnam, Seminole and Volusia. They implement the program in their respective counties with oversight to the remaining fifty-one counties. These lead health departments have solid partnerships with all six
Komen Affiliates in Florida, as well as the Komen grantees, to ensure that duplication of services does not occur.

The Florida Department of Health federal grant, as previously described, provides FBCCEDP services in these Susan G. Komen Florida Affiliate service areas through these lead agencies:

- Residents in the Komen Central Florida Affiliate (Brevard, Flagler, Lake, Marion, Orange, Osceola, Seminole, Sumter, and Volusia counties) are provided FBCCEDP services by Brevard, Seminole, Osceola and Volusia County’s Health Department.
- Residents in the Florida Suncoast Affiliate (Hillsborough, Manatee, Pasco, Pinellas, Polk and Sarasota counties) are provided FBCCEDP services by Hillsborough, Manatee, Pasco, and Pinellas County’s Health Department.
- Residents in the Affiliate service area (Miami-Dade, Broward and Monroe counties) are provided FBCCEDP services by the Broward and Miami-Dade County’s Health Department.
- Residents in the North Florida Affiliate (Duval, Nassau, St. Johns, Baker and Clay counties) are provided FBCCEDP services by the Duval County’s Health Department.
- Residents in the South Florida Affiliate (Palm Beach, Martin and St. Lucie counties) are provided FBCCEDP services by the Brevard and Broward County’s Health Department.
- Residents in the Southwest Florida Affiliate (Lee, Collier, Charlotte, Glades, and Hendry counties) are provided FBCCEDP services by the Manatee County’s Health Department.

Each of the six Komen Affiliates in Florida, as well as many of the Komen-funded grantees, has a direct relationship with the regional Department of Health that administers their area’s FBCCEDP. This includes phone calls, e-mails, and face-to-face meetings, as needed, to coordinate patient services and to determine available funding.

The six Komen Affiliates in Florida work together throughout the year on public policy issues. Known as the Komen Florida Public Policy Collaborative, this group recognizes that a good working relationship with the Health Departments and FBCCEDP is necessary in order to ensure that as many low-income women as possible with no insurance or who are underinsured receive services. This relationship is critical to reducing late-stage incidence rates and trends in all target areas.

Both as individual Affiliates and as the Komen Florida Public Policy Collaborative, relationships will continue to be improved through timely interaction with designated Regional Directors within the FBCCEDP system. For example, the Florida Collaborative meets monthly by phone and each member has the capacity to have items added to the agenda. Therefore, if there were any questions or concerns that might be systemic in nature, an email or phone call to the FBCCEDP contact in Tallahassee would follow, with the outcomes being reported back to the group.

Likewise, the Florida Collaborative coordinates during its annual meeting with representatives from FBCCEDP on the state and local level. Questions or concerns are gathered in advance of the annual phone call made by the Florida Collaborative to FBCCEDP. These practices will be continued throughout the next four years.
Florida ranks third in the United States in the number of new breast cancer cases per year and second in the number of deaths, with approximately 15,700 Floridian women diagnosed and an estimated 2,700 more expected to have died from this disease in 2013, highlighting the impact of FBCCEDP and its importance to Komen’s Florida Affiliates. Komen is a leader in providing access to breast cancer screening. Komen Affiliates are working tirelessly to preserve state screening programs across the state so that access to potentially life-saving screening through FBCCEDP and Medicaid-funded treatment is protected during these tough economic times (American Cancer Society Cancer Action Network, 2013).

New health care laws will help many low-income, underserved women obtain breast and cervical cancer screening tests by expanding insurance coverage and by removing co-pays for these services. But even with good health insurance, many women will still have issues accessing care due to geographic isolation (living far away from needed health care services); problems understanding cancer screening and how it applies to them; not having a provider who recommends screening; inconvenient access to screening services; and language barriers. Situations like these are where FBCCEDP will continue to help in the future.

**State Comprehensive Cancer Control Coalition**
Florida’s State Comprehensive Cancer Control Coalition is called Cancer Control and Research Advisory Council (CCRAB). Its main goals are:
- Goal I – Development of System Capacity
- Goal II – Prevention
- Goal III – Treatment and Access to Care
- Goal IV – Survivorship

The state is divided into six CCRAB regions with the corresponding Komen Affiliates’ service areas listed below:
- Southeast Florida Cancer Control Collaborative: Komen South Florida, Komen Miami/Ft. Lauderdale
- East Central Florida Cancer Control Collaborative: Central Florida
- Southwest Florida Cancer Control Collaborative: Florida Suncoast, Southwest Florida
- Northeast Florida Cancer Control Collaborative: North Florida and Central Florida
- Northcentral Florida Cancer Control Collaborative: None
- Northwest Florida Cancer Control Collaborative: None

Each region had developed a Strategic Plan that integrates:
- A coordinated approach among public and private cancer control stakeholders to implement cancer activities statewide
- Collaborative efforts through membership, partnerships, and joint programs with other organizations

Objectives to accomplish regional goals include:
- Recruit and maintain active membership in each region
• Develop and implement a communication plan
• Develop and enhance partnerships with cancer-related organizations
• Re-evaluate strategic plan before each meeting
• Increase engagement with the University of Florida affiliated programs
• Facilitate networking events

It is a priority for each of the Florida Affiliates to be active members of their regional CCRAB. In 2014, the Komen Florida Public Policy Collaborative will explore the possibility of attaining membership as a voting member on the CCRAB Board.

During the next four years, with the expanded involvement of all the Florida Affiliates, the Affiliates will be able to help CCRAB intensify its efforts to reach their goals and objectives in each region.

Specifically, the Florida Affiliates will focus on:
• Prevention (Goal II) – Floridians practice healthy behaviors associated with prevention of cancer to reduce risk
  o Komen Florida Affiliates will help develop and participate in CCRAB breast cancer risk reduction initiatives
• Treatment and Access to Care (Goal III) – Floridians have access to appropriate health information and effective health services for the timely detection, diagnosis, and treatment of cancer
  o The Komen Florida Public Policy Collaborative is involved with CCRAB’s development of legislation that directly impacts Goal III – Treatment and Access to Care.
• Survivorship (Goal IV) – Floridians affected by cancer are aware of and have access to quality, appropriate services for quality of life, palliative care, and survivorship
  o Since the Affordable Care Act (ACA) has stated that survivorship plans are part of the treatment of a cancer patient, the Komen Florida Affiliates will work hard alongside CCRAB to ensure this happens.

The Affordable Care Act
The major goals of the Patient Protection and Affordable Care Act (commonly known as the Affordable Care Act or ACA) are to expand access to care through insurance coverage, enhance the quality of health care, improve health care coverage for those with health insurance and to make health care more affordable.

To improve coverage for those with health insurance and to enhance the quality of health care the ACA has the following mandates:
• Prohibit insurers from denying coverage based on pre-existing conditions
• Prohibit insurers from rescinding coverage
• Prohibit annual and lifetime caps on coverage
• Provide coverage of preventative services with no cost-sharing
• Establishes minimum benefit standards
Implementation of the Affordable Care Act began in every state with coverage through the Marketplaces on January 1, 2014, with enrollment beginning October 1, 2013. States can elect to build a fully State-based Marketplace, enter into a state-federal Partnership Marketplace, or default into a Federally-facilitated Marketplace. The Affordable Care Act (ACA) directs the Secretary of Health and Human Services (HHS) to establish and operate a Federally-facilitated Marketplace in any state that is not able or willing to establish a State-based Marketplace.

The ACA works to significantly reduce the number of uninsured by providing a continuum of affordable coverage options through Medicaid and new Health Insurance Exchanges (Marketplaces). Each state has the ability to expand Medicaid to all individuals not eligible for Medicaid under the age of 65 including families, pregnant women, children, adults without disabilities and without dependent children with incomes up to 133 percent of the Federal Poverty Level (FPL) (Appendix A), plus a five percent income disregard in essence making the allowable FPL 138 percent. If states choose to expand Medicaid in 2014, the federal match is 100 percent. The match will continue to adjust over the years until 2020 and beyond when the match will remain at 90 percent.

The ACA has established Essential Health Benefits (EHB) categories which are health care services that must be covered starting in 2014. Plans in the individual and small group markets both inside and outside of the exchanges (but not including grandfathered plans), Basic Health Programs and Medicaid benchmark and benchmark-equivalent plans all must include the EHB package.

**ACA Implementation in Florida**

Florida did not opt to set up its own Marketplace; therefore, they defaulted to a Federally-Facilitated Marketplace (FFM). For the 2014 Open Enrollment period, 983,775 Floridians selected a Qualified Health Plan (QHP) and 180,479 were determined eligible for Medicaid/Children’s Health Insurance Plan (CHIP) by the Marketplace (Appendix B) (ASPE Office of Health Policy, 2014).

Marketplace QHPs can include federal subsidies – premium tax credits and cost-sharing reductions – to help pay for insurance (GetInsured Team, 2013). These federal subsidies make coverage more affordable for individuals who were previously uninsured or underinsured due to the cost.

Premium tax credits help people pay their monthly health insurance premiums and cost-sharing reductions (CSRs) help people pay for their out-of-pocket costs (such as co-pays, deductibles, and coinsurance). The government determines who will qualify for a premium tax credit as well as CSRs based on household income. The lower the person’s income, the more financial assistance for which they may be eligible. Table 3.1 provides a summary of premium tax credits and CSR eligibility levels.
The ACA includes provisions for enrollment assistance entities that guide consumers through the process of applying for and choosing new coverage options in the Marketplace. The provisions required states to establish grants for a navigator program. Navigators provide outreach and education, raise awareness about the Marketplace, and assist with enrollment. Several other grants, programs, and organizations provide health insurance education and enrollment assistance.

**Medicaid Expansion in Florida**

The Supreme Court ruling in June 2012 made Medicaid Expansion optional for each state. Although twenty-six states and the District of Columbia moved forward with Medicaid Expansion in 2014, Florida did not choose to expand Medicaid. Table 3.2 describes the levels of coverage available for segments of Floridians through the ACA.

### Table 3.2. Summary of affordable insurance programs by population segment

<table>
<thead>
<tr>
<th>Segment</th>
<th>Affordable Insurance Programs and Eligibility Levels</th>
</tr>
</thead>
</table>
| Pregnant women                               | • Florida provides Medicaid coverage up to 191% of the FPL  
|                                              | • For households with higher incomes, the Marketplace provides QHPs with federal subsidies up to 400% of the FPL |
| Parents (age 19+ with qualified dependent children) | • Florida provides Medicaid coverage up to 31% of the FPL  
|                                              | • Households above 31% but below 100% of the FPL fall into a coverage gap  
|                                              | • For households with higher incomes, the Marketplace provides QHPs with federal subsidies up to 400% of the FPL |
| Childless adults (age 19+)                   | • Florida does not provide Medicaid coverage  
|                                              | • Households below 100% of the FPL fall into a coverage gap  
|                                              | • For households with higher incomes, the Marketplace provides QHPs with federal subsidies up to 400% of the FPL |
Impact of ACA on Uninsured Floridians

A central goal of the ACA is to significantly reduce the number of uninsured by providing a continuum of affordable coverage options through Medicaid and new Marketplaces.

Nationally, the estimate of residents that are left uninsured after the implementation of ACA is approximately 23 million. Most of those residents fall into one of the following categories:

- Illegal immigrants (estimated eight million residents)
- Eligible, not enrolled
- Opting to pay penalty. Those whose insurance would cost more than eight percent of household income are exempt from paying penalty.
- Those who live in states that opt out of Medicaid expansion and don’t qualify for existing Medicaid or subsidies.

In the 2012 population estimate from the American Community Survey, using the most recently published US Census Bureau (2012) report prior to the implementation of the Affordable Care Act, the total population of the state of Florida is 19,011,070 and the total of uninsured residents is 3,815,840 making the percentage of uninsured residents 20.1 percent.

The State of Florida has elected to default into a federally-facilitated marketplace and not to expand the state’s Medicaid coverage at this time. With 3,815,840 uninsured residents, the real story for the State of Florida is the major reduction in the number of uninsured residents if Florida elected to expand Medicaid. As reported by The Henry J. Kaiser Family Foundation (January and April 2014), of the 1,307,000 that would have been eligible for Medicaid had Florida chosen to expand only 94,000 are eligible as Medicaid stands in July 2014. Without expansion, 1,212,000 residents are excluded from Medicaid because the State did not elect to expand coverage. This reflects approximately 764,000 residents (<100 percent of the Federal Poverty Level) that currently fall into a coverage gap, and another 448,000 (100-138 percent of the Federal Poverty Level) who otherwise may have been eligible for Marketplace tax credits.

In one of several reports on the state of insured versus uninsured for Florida, prior to and post ACA implementation, The Health Affairs Blog Report (June 6, 2013) reported estimates of 3,765,000 uninsured residents prior to the implementation of ACA, 3,080,000 uninsured residents post ACA with Florida opting out of expansion, and a post ACA estimate of 1,917,000 uninsured residents if Florida chose to opt in to Medicaid expansion. This report shows an estimated 1,163,000 reduction in uninsured residents in the post-ACA implementation if Florida elected to expand Medicaid.

The Henry J. Kaiser Family Foundation (April 24, 2014) reports on Florida break the population into insured categories and uninsured percentages as follows in Table 3.3.

<table>
<thead>
<tr>
<th>Location</th>
<th>Employer</th>
<th>Other Private</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Other Public</th>
<th>Uninsured</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td>41%</td>
<td>5%</td>
<td>14%</td>
<td>17%</td>
<td>2%</td>
<td>21%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, March 2012-2013
**Implications of the ACA on the Florida Breast and Cervical Cancer Screening Program**

The Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP) is currently funded for the 2014 fiscal year at $4.8 million in federal funds and an unprecedented $1.8 million in state-matched funds (American Cancer Society Cancer Action Network, 2014). The FBCCEDP serves 5.4 percent of eligible Floridian women, some of whom would also be eligible for either Medicaid or a Marketplace QHP with federal subsidies. However, due to the barriers previously stated, between 3.7-3.8 million Floridians are predicted to be uninsured. Consequently there is a critical need for adequate FLBCCEDP funds to provide low-income women access to early detection and prevention screening, and treatment services.

The CDC is partnering with George Washington University to measure the impact of the ACA of NBCCEDP-eligible women and make recommendations for the future of the NBCCEDP (Centers for Disease Control, 2012).

**Implications of the ACA on Health Care Providers in Florida**

With the introduction of the ACA, access to affordable health insurance, the US health care system braced for the addition of a massive number of newly insured individuals. Initial calculations ranked Florida among the top three states that could be hit the hardest by the influx of newly-insured patients.

One of the key questions many have asked since the passage of the Affordable Care Act is what does this mean for the health care providers charged with delivering medical care under this new system? The answers are plentiful and as diverse as opinions on the ACA itself. The following is a review of a number of issues that, while not all-encompassing, are expected to affect the health care landscape due to the ACA.

- **Doctor-patient relationships placed ahead of insurance company profits**
  The Affordable Care Act is intended to take the power away from the insurance companies that often controlled much of what occurred in hospitals and doctor’s offices, and place control back in the hands of the doctors, allowing them to treat their patients as they see best. For example, insurers are prohibited from denying coverage due to a pre-existing condition and/or rescinding coverage, and annual limits on insurance coverage are eliminated as are lifetime limits. According to a state-by-state report on Florida prepared by the White House (n.d.), 7,839,000 Floridians with pre-existing conditions will no longer have to worry about being denied coverage or charged higher rates, and 5,587,000 Floridians will no longer have to worry about annual limits.

- **Less paperwork should translate into more time with patients**
  With a focus on allowing health care providers to do what they do best – care for patients – the ACA should lessen the amount of insurance paperwork and decrease administrative hassles by instituting a number of changes to standardize billing and require health plans to adopt and implement rules for secure, electronic transfer of health information. The ACA invests in programs to help health care providers transition to electronic record systems and adopt new payment and record-keeping...
systems, with the goal of reducing administrative burdens.

- **Changes in how health care is paid for and delivered**
  According to a Public Health Report by the US National Library of Medicine, National Institutes of Health (2011, Jan-Feb.), the ACA is introducing broad changes to both Medicare and Medicaid that will include allowing the Secretary of the US Department of Health and Human Services (HHS) and state Medicaid programs to test new payment structures and new service delivery modes. These changes are intended to begin the process of realigning the health care system for long-term changes in the quality of care, the organization and design of care and health information transparency. Some worry that this may be too much power in the hands of the HHS.

  Arnold Milstein, MD, MPH (as cited in Hammerstrom, 2012), who has spent the past 15 years at the forefront of federal health policy changes, suggests that the Medicare payment structure under the ACA is also designed to do a better job of rewarding health care providers and hospitals that are able to achieve the best possible quality of care, including patient experience, for the lowest amount of money. Health care providers will see a gradual shift from incentives and payments made based on volume of services to rewarding value of service. Doctors and hospitals who are more cost effective, and who achieve the best outcomes with the lowest amount of insurer and patient costs, will be paid more favorably than those who do not.

- **Access to preventive care**
  Usha R. Ranji (as cited in Gordon, 2013), associate director for Women's Health Policy at the Kaiser Family Foundation, sees some components of the ACA that have already taken effect. With health insurance exchanges, employer mandates, and for many state Medicaid expansions, it is estimated that about 19 million women will gain health insurance. Many of these women are between the ages of 50 and 64, too young to qualify for Medicaid but not necessarily able to pay for medical bills. These women will benefit from preventive care, now available through the ACA, such as mammograms, Pap tests, and colonoscopies, without having to pay a deductible, co-pay or coinsurance. According to a state-by-state report on Florida prepared by the White House (n.d.), 3,762,000 individuals with private insurance benefited from at least one free preventive care service in 2011 and 2012. In the first 11 months of 2013, an additional 1,778,900 people with Medicare received at least one preventive care health service at no cost to them.

- **Shortage of health care professionals**
  According to the Association of American Colleges (n.d.), by 2020 the United States will face a shortage of more than 91,500 physicians, with the number growing to more than 130,000 by 2025. According to the “United States Registered Nurse Workforce Report Card and Shortage Forecast” published in the American Journal of Medical Quality (2012), it was found that a shortage of registered nurses is also projected to spread across the country, with the most intense shortages forecasted to occur in the
South and the West. Health care provider shortages are also expected to adversely impact the pool of volunteer health care providers lending their services to free clinics around the nation. Clinics report that their concern is that providers will be so inundated with patients in their regular practice/hospital setting, that they will not have the time to volunteer for free clinics.

In an attempt to address these issues, the Affordable Care Act has $1.5 billion in funding allotted for the National Health Services Corps, which provides support to health care professionals in exchange for their service in shortage areas. The ACA also invests more money toward training by offering more graduate positions and scholarships for primary care doctors, who according to the Journal of the American Medical Association (as cited in Mercer, 2013) account for only one in five graduating medical residents. An article in the Medical Practice Insider (Palmer, 2012) estimated that in conjunction with the American Recovery and Reinvestment Act of 2009, the ACA will allow for the training of more than 15,000 new primary care providers in the next few years. Plus, nurse practitioners will also have the ability to receive additional training in new nurse-managed health clinics, in exchange for working in underserved communities.

- **Increased competition for current patients**
  Because of the ACA, newly-insured patients may enroll in plans that have specific provider networks. Therefore, health care providers may face increased competition for current patients who become more attractive to other providers. For example, in 2013 and 2014, Medicaid payment rates for primary care increased significantly, making these patients more attractive to other providers. To ensure that patients have the option to stay with their current health care provider, many providers are participating in the networks of the health insurance plans in which their patients will enroll, including QHPs and Medicaid managed care plans.

- **Funding cuts to disproportionate share hospitals**
  Historically, Medicaid and Medicare provided additional funding to Disproportionate Share Hospitals (DSH), which, as their name implies, serve a disproportionate number of underserved patients. These may include critical access hospitals, sole community hospitals, Rural PPS hospitals, and teaching hospitals. But starting in 2014, these hospitals will face a reduction in funding because the number of uninsured patients will decline due to the ACA. According to a 2013 CRS Report prepared for members and committees of Congress (Mitchell, 2013), during fiscal year 2013 DSHs were preliminarily allotted $11.5 billion in federal funds to offset the costs of providing uncompensated care. However, in September 2013, the Centers for Medicare and Medicaid Services (Adams, 2013) ruled that DSHs will face $500 million worth of cuts in FY14 and $600 million in cuts in FY15. These cuts are of particular importance to states that did not expand Medicaid, Florida included, as they will continue to have more uninsured patients.
• **Impact on and continued need for free clinics**
In a 2013 survey conducted by AmeriCares U.S. Medical Assistance Program (McGuire & Meehan, 2014), 203 clinics in their domestic safety net partner network weighed in on the impact of the ACA. Thirty-two percent of those that responded to the survey anticipate an increase in the number of patients they will see as a result of the ACA, and 40 percent anticipate an increased need for donated services and resources such as medical supplies. Free clinics report that they have other obstacles to face like losing donors who think that free clinics are no longer needed with the passage of the Affordable Care Act. They often have to explain that the plethora of patients who haven’t made the transition to private insurance are still being served by free clinics. It appears that regardless of the health care landscape, so long as there remain uninsured or underinsured individuals, free clinics will continue to be a necessity across the nation.

• **Exclusion of undocumented populations**
The Affordable Care Act excludes undocumented immigrants, which will result in this population remaining largely uninsured and with limited access to health care. According to recent report by the State Health Access Data Assistance Center and the Robert Wood Johnson Foundation (2013), immigration status will be the reason why 17 percent of all low-income, uninsured, non-elderly adults will remain uninsured. South Florida is home to a large population of undocumented immigrants, which seems to not be impacted by the ACA at all. Safety net hospitals in states where large populations of undocumented immigrants live, including Florida, will feel the cuts to DSH payments significantly. Free clinics will be in high demand in these states as a result.

• **False sense of security for patients, false sense of success for providers**
Many health care providers are concerned about patients who enroll in a health plan but do not fully understand what plans are available and how those plans impact their benefits. While many people enrolled during the open enrollment period, the true test will be how many will remain in a health plan. Many patients choose the cheapest plan not realizing that the high deductibles and co-pays do not cover the services they need. Additionally, for many the costs of the deductibles and co-pays are simply more than they can afford. These problems can create a false sense of success for providers who see the costs for uncompensated care decline, only to rise again as people drop out of health insurance plans. According to a report produced by the Robert Wood Johnson Foundation (Buettgens, Kenney, & Recht, 2014), in Florida, where the state government declined to expand Medicaid, only 44 percent of the uninsured were eligible for assistance.

**Implications of the ACA for the Affiliate**
Overall, the Affordable Care Act should reduce the number of women who need financial assistance for breast health services. The ACA should provide the health care industry with opportunities to thrive, not only because quality of patient care is now the priority, but also because information management is migrating to a system that is hassle-free and streamlined. Although many Floridians will now have access to breast health care as newly insured patients,
there are many at-risk groups who may not have access to the entire continuum of care. While the ACA has given providers the tools to support these efforts, it will take some time to see if the policies and methods implemented will have a lasting effect on the health care system.

Of particular concern are patients who fall in the “Medicaid Gap,” undocumented women and men who are not eligible for the ACA, and Floridians living in areas with limited access to health care. The Florida Affiliates will want to measure the impact of the ACA on their individual Community Health Grant Programs to determine the impact of the ACA on their service areas. Currently, Komen Florida Affiliates allocate funds via grants to certain entities that provide: 1) full continuum of care for breast health services; 2) breast health awareness education programs; and/or 3) navigation programs for breast cancer patients and survivors. The ACA mandated a variety of benefits which positively impact the majority of the United States’ population, including women receiving breast health services through funding provided by Komen Miami/Ft. Lauderdale. The increased availability of free and low-cost insurance programs through the new Marketplaces combined with guaranteed coverage and the allowance of payment of premiums by third parties provides the opportunity to consider new options for funding care across the continuum. Figure 3.5 provides a summary of ACA provisions most relevant to populations served by Komen Florida Affiliates.

**Figure 3.5. Summary of ACA provisions most relevant to Affiliate target populations**

In addition to Medicaid, the new Marketplace QHPs provide comprehensive health coverage which includes coverage for the full continuum of care (as well as screening mammograms beginning at age 40). Further, the Marketplace will determine eligibility for federal subsidies to assist with premium payments and cost-sharing reductions on health services. Florida Komen Affiliates will educate their respective grantees and communities about affordable health coverage programs and partnering organizations with enrollment assisters, such as Enroll America. As a result, overall health needs for those most at risk will improve, in addition to increasing access to the continuum of care for breast health services.
Affiliate’s Public Policy Activities
In the summer of 2012, the six Komen Affiliates operating within the state of Florida formalized their public policy activities by creating the Komen Florida Public Policy Collaborative. This partnership consists of Komen Central Florida, Komen North Florida, Komen Florida Suncoast, Komen Southwest Florida, Komen South Florida, and Komen Miami/Ft. Lauderdale. Communication and membership guidelines were generated, and an effective leadership structure was established. A Chair, Vice Chair, and Past Chair comprise the executive body with the provision that at the conclusion of each legislative year the Vice Chair is promoted to Chair, and the Chair becomes Past Chair to serve as a mentor. The purpose of the Collaborative is to improve breast health care services in Florida through advocacy. The Florida Komen Public Policy Collaborative has the power to meaningfully affect change because of its ability to pool resources, streamline advocacy processes; and convey to legislators that Komen positions on various advocacy issues are supported statewide.

The Collaborative hosts an Annual Meeting at which the policy and legislative issues for the upcoming year are articulated and prioritized. These issues are determined considering the overall Susan G. Komen National policy directives, as well as those that are state specific and likely to result in improving the quality of care for Florida residents affected by breast cancer. Partners from organizations focused on curing cancer are invited to participate including but not limited to the American Cancer Society, Cancer Control and Research Advisory Council (C-CRAB), Florida Osteopathic Association, Florida Society of Clinical Oncology, Susan G. Komen, legislators, and Florida Department of Health (FBCCEDP).

Below is the framework for the Florida Komen Public Policy Collaborative activities which are reviewed at the Annual Meeting and updated throughout the year:

1. Refine “talking points and fact sheets” in preparation of the legislative visits in order that each Affiliate’s local area information can be included with both state and national data, and aligned with the Susan G. Komen policy priorities.

2. Meet with state and national legislators and/or their aides. At each office visit, material from the Affiliate is distributed in order that the legislator/staff understands how to reach the Affiliate should a constituent be in need of breast health resources.

3. Meet with the governor and/or staff to present breast health policy matters.

4. Present important breast health advocacy topics at local delegation hearings.

5. Attend Lobby Day. This is a one-day event in which multiple organizations and independent advocates from throughout the state visit the Florida State Capitol to urge legislators to support breast health legislation. Prior to Lobby Day, the Collaborative identifies the legislators who are members of the specific committees responsible for voting on important breast health/breast cancer legislation.
6. Outreach to the Affiliate’s contact lists to telephone and email legislators to promote important breast health legislation and thank them for their efforts.

7. Outreach to breast cancer survivors to share information from their experiences that is pertinent to the proposed legislation via media interviews, social media posts, and on Affiliate websites.

8. Outreach to constituents to provide in-person testimonials at Legislative Committee meetings in order to advocate for breast health legislation.

9. Coalition building with organizations sharing similar missions in order to present a unified message to legislators. Coordinate collateral materials for distribution that enhances the message.

10. Encourage legislators to sponsor and co-sponsor bills, and when they do, acknowledge their efforts.

11. Create petitions to be circulated on Race Day to garner support for passage of Florida breast health legislation and budget support.

12. Track the progress of breast health legislative bills and budgeted items, and report the status during Collaborative meetings, and to Affiliate leadership.

13. Raise awareness of breast health policy issues during Breast Cancer Awareness Month and invite legislators to participate in Breast Health Awareness local events.

14. Invite legislators and aides to participate in Affiliate-driven events throughout the year, and the Florida Komen Public Policy Collaborative Annual Meeting.

The level and scope to which each Affiliate is able to execute public policy actions depends on their staffing capacity/resources and proximity to the State Capitol in Tallahassee. Also, if their representative/staff serves as a current officer of the Collaborative (Chair, Vice Chair, Past Chair) there are increased duties. Other factors include the number and time commitment from volunteers, interns, board support for advocacy and the number of bills that have been sponsored related to breast health concerns. One of the biggest challenges for policy implementation is the timing of the Florida legislative session which is only sixty days. Another substantial challenge is the absence of a Komen Affiliate in Tallahassee which is a tremendous disadvantage, especially during the legislative session. Given these parameters, however, the minimum threshold of public policy work that the Komen Florida Public Policy Collaborative successfully accomplishes each year includes:

- Selection of policy and legislative focus areas and then conducting advocacy on the local, state, and federal level
- Contacting legislators during August recess and Breast Cancer Awareness Month providing education on current policy and legislative issues
Policy and Legislative Issues
During the 2013 and 2014 legislative sessions, three main policy issues were highlighted:

- Breast and Cervical Cancer Early Detection Program;
- Breast Cancer Research and;
- The Cancer Drug Parity Act

Legislative visits were made to both state and federal representatives to advocate on these issues by Komen staff and volunteers.

On a state level, all of the Florida Komen Public Policy Collaborative members advocated for the continued support of the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP). The Affiliates and their representatives requested increased funding for this program through presentations made at multiple delegation hearings. The result of the State of Florida electing not to expand Medicaid coverage, is that there are more Florida women who fall in the gap because they are both ineligible for Medicaid enrollment, as well as for the Exchange enrollment through the Affordable Care Act. Consequently there is a critical need for adequate FLBCCEDP funds to provide low-income women access to early detection and prevention screening, and treatment services.

On a federal level, the Florida Komen Public Policy Collaborative members urged legislators to support the Cancer Drug Coverage Parity Act, Breast Cancer Research, and the National Breast and Cervical Cancer Early Detection Program.

The Collaborative emphasized the need to continue and increase funds for the National Breast and Cervical Cancer Early Detection Program throughout America to help people unable to access women’s breast health services. The second policy area, breast cancer research, is an important advocacy focus because funding is essential for producing better preventive, diagnostic, and treatment methods. Florida is home to research universities (such as but not limited to University of Miami, University of South Florida, University of Florida), as well as research institutions (such as but not limited to Scripps) that work diligently to find anti-cancer healing and preventive drugs to battle this disease. The third policy issue is the federal Cancer Drug Coverage Parity Act which seeks to eliminate insurance coverage disparity between orally administered anti-cancer medications and intravenous anti-cancer drugs. This disparity is due to the classification of intravenous drugs as a medical benefit whereas oral drugs are designated as a pharmacy benefit with substantially higher out of pocket expenses. During 2014, each federal representative visited was briefed on the need for physicians to be able to prescribe medicines for cancer treatment based on providing the best option for survival and to remove insurance constraints.

Collaborative members were extremely proud to share with their federal legislators that Komen had a lead role in passing Florida legislation for cancer treatment parity in 2013 and urged them to support parity on a national level.
History of the Passage of the 2013 Florida Cancer Treatment Fairness Act

In 2013 Florida joined the 21 other states that had passed a parity law. Advocacy on this issue commenced in 2010 with the support of all six Florida Komen Affiliates and Komen’s national office. In 2012 Representative Jeanette Nunez and Senator Rene Garcia introduced the necessary bills but the bills did not advance through Committee hearings. The following year, Komen Florida Public Policy Collaborative led The Alliance for Access to Cancer Care consisting of more than 24 patient and physician groups, research and treatment facilities. The Alliance, consisting of Komen and other key partners, was responsible for building momentum for the passage of the Florida Cancer Treatment Fairness Act into law. Senator Lizbeth Benacquisto and Representative Debbie Mayfield sponsored the bills and Governor Rick Scott signed them into law. Komen Affiliate representatives alongside the Alliance and others, presented before seven different committees in the House and Senate over a sixty-day legislative session, advocating for the rights of cancer patients to access lifesaving anti-cancer oral medications. This was a huge victory for Floridians and a major success for the Collaborative and its partners.

Breast Cancer Awareness Month (BCAM)

Breast Cancer Awareness Month also known as BCAM occurs each year in October and consists of a variety of activities in which the Florida Komen Affiliates take part. As a Collaborative, members try to parallel each other's BCAM activities. However, since Florida is particularly diverse Affiliates also work independently based upon the needs of their service area. All Affiliates contact both state and national legislators by phone, emails, or letters to join Komen on joint works unique to their service area.

There are many examples of BCAM activities throughout the state. Several Affiliates partner with the state of Florida to issue a proclamation recognizing October as Breast Cancer Awareness Month in Florida. In 2012, the mayor of West Palm Beach issued a proclamation acknowledging Komen South Florida Affiliate’s commitment to educating people on breast health and facilitating breast cancer treatment. Florida Komen Affiliates invite local legislators to participate in their Race should it be occurring during or after BCAM (such as Miami/Ft. Lauderdale, North Florida, South Florida, Suncoast, and Central Florida).

Komen Suncoast Affiliate has worked with the Polk County Board of Commissioners in October to designate the week leading up to the Polk Race as “Make Polk Pink Week.” In addition, Komen Suncoast Affiliate works with the city to “pink the pier”, an iconic landmark, to further their overall message during Breast Cancer Awareness Month. Komen South Florida invites the mayor to speak at the unveiling of a pink bus that promotes breast cancer awareness messaging in Palm Beach County during October. A common activity for all Affiliates is asking legislators to wear pink and display pink ribbons in their offices.

It is a priority of the Komen Florida Affiliates to develop new and nurture existing relationships with policy makers and local officials. These necessary partnerships are fully apparent during Breast Cancer Awareness Month along with their positive effects in spreading Komen’s overall vision and hope for the future.
**Potential future service area and/or state public policy activities**

State Public Policy activities and potential Florida Komen Public Policy Collaborative activities for the future include the following:

- Florida Breast and Cervical Cancer Early Detection Program
- Patient Access Issues

From 2008-2013, FBCCEDP detected 1,572 invasive breast cancers with about 240,000 Florida women eligible for FBCCEDP breast cancer screenings. However, the program had only enough funding to screen 5.4 percent of its total eligible population. As previously stated, the demand for FBCCEDP services will continue to surpass the availability of funds. Therefore, the Collaborative will continue to advocate for increased funding to address this need.

As the Affordable Care Act unfolds and is reassessed, its strengths and weaknesses will help shape future health policy directives. The Collaborative will need to evaluate the political landscape to determine whether Florida’s politically conservative environment will be able to afford large scale access to care.

During 2014, the Florida Komen Public Policy Collaborative gathered information related to patient access issues. The Florida Komen Public Policy Collaborative was invited to join a Coalition led by the Florida Medical Association to support the bills promoting Patient Access issues. Many of the members of the Coalition partnered with Komen on the passage of Florida’s Cancer Treatment Fairness Act.

**Health Systems and Public Policy Analysis Findings**

In defining the target communities for Komen Miami/Ft. Lauderdale it is clear that further review of the Health Systems Analysis and Continuum of Care considerations are needed to evaluate the role that Affiliate funding plays in the overall impact of breast health services in the service area. A hard evaluation needs to be made to ensure that current partners and grantees are in fact, making the most impact for the dollars spent in these communities. There are several hospitals and community organizations that are not currently partners or grantees, which directly touch the target community and might align with the funding priorities of the Affiliate going forward.

With Komen Miami/Ft. Lauderdale having the number one and two counties in the State based on population, greater emphasis needs to be placed on Public Policy efforts and developing those political and impactful relationships. The Affiliate has a very close relationship to Congresswoman Debbie Wasserman Schultz, who is a breast cancer survivor. Currently, the Affiliate has sent numerous e-mail and letter requests to meet during the current recess. With the successful passing of the Oral Parity Bill last year, the Komen Florida Public Policy Collaborative has taken a leadership role in the cancer arena in the State. The Collaborative has taken steps to educate and train the staff and volunteers at each Affiliate to ensure that the message is a cohesive one and stays within the guidelines of the National Advocacy Policies.
Qualitative Data Sources and Methodology Overview

Methodology
Prior to beginning the qualitative data collection process, the Community Profile Team at Susan G. Komen Miami/Ft. Lauderdale met to review both the quantitative data and Health Systems and Public Policy Analysis sections. The review of the data prompted a discussion on the breast health concerns that warranted further investigation and guided the team’s efforts when determining what questions to ask throughout the qualitative data collection process. The team decided to focus their efforts on questions that addressed access to care, barriers, disparities, survivorship and health care system issues (i.e. bottleneck, capacity and timeliness issues).

Each team member was tasked with reviewing the “Qualitative Question Bank” provided by Komen Headquarters and selecting, at a minimum, two questions per issue identified. Team members were also encouraged to provide their own questions where needed.

After much discussion the team decided to focus on two data collection methods: key informant interviews and focus groups. The team quickly ruled out document reviews and observations as methods because they felt these would take a lot of time to complete that they simply did not have. Surveys were considered but ultimately ruled out for a number of reasons, the first being the lack of email/mail addresses for the target communities. The team was also concerned that the initial response would be low and thus they would have to dedicate a large portion of their time to making sure that participants completed and returned the surveys. Another factor that was considered was that many constituents in the Affiliate territory do not speak/read English, thus being unable to complete the survey. For these reasons, the team agreed that focus groups and key informant interviews appeared to be the most effective forms of data collection.

Focus groups have been documented to be an excellent method for data collection throughout the literature (Gibbs, 1997, Morgan & Krueger, 1993, Morgan, 1998, Powell & Single, 1996). An important aspect of focus groups is that they allow members of the group to share their experiences and perspectives on a particular topic that is of interest to them. They are used to explore and discover accomplishments as well as allow the researcher to understand people’s thoughts and actions. The conversation among the group gives the interviewer an in-depth view of the group feelings as well as observed both verbal and nonverbal responses from the group (Lawrence, 2014).

Once all questions were submitted, the team narrowed the questions down to a workable number and agreed on what questions should be asked of each group based on the target community and the quantitative data collected. A number of resources were developed to aid in the data collection process – scripts, question banks, focus group invitations, consent forms and demographic form (for focus groups). Both consent forms and invitations were translated via a professional translation company into both Spanish and Creole as one target community in particular was linguistically isolated women. At that point in the data collection process, the team compiled a list of potential participants for the interviews and focus groups.
One team member, with experience in qualitative data collection, offered to serve as the moderator for all focus groups. Affiliate staff worked with the remaining team members to secure, schedule and coordinate the focus groups. As this took a lot of careful planning, it was the priority. Both the moderator and one staff member attended each of the focus groups, with additional team members serving as note takers. Each focus group was recorded using digital recorders.

While key informants were provided with the option of doing in-person or phone interviews, all key informants opted for the phone option as it was easier to coordinate. Three team members offered to conduct interviews and did so using a secure conference call line that allowed for recording.

As previously mentioned, in an effort to contribute to the overall quality of the study, the team used multiple techniques of gathering and/or handling data, referred to as triangulation. The combination of multiple data collection methods allowed for the team to use an alternative methodology to validate the findings of the data. Triangulation further allowed for the team to gain a holistic view of the phenomenon being studied and at the same time added to the team’s understanding of breast cancer. This method allowed for data to be collected at different points in time, data at multiple sites and from different levels of persons. Although there are different types of data triangulations, for the purpose of the qualitative data collection process of the Community Profile, the use of person data triangulation in qualitative research was utilized. In other words, data was collected at several levels of persons. Data was collected for key informants, survivors, and women from the identified prior groups and women who may or may not have entered into the continuum of care.

**Sampling**

Sampling refers to selecting a group of people, events, or behaviors with which to conduct a study. For the purposes of the qualitative aspect of the Community Profile, a non-probability sampling method was utilized. Because the sample must accurately reflect the population under study, the following non-probability sampling techniques were utilized through the data collection process:

- **Convenience Sampling**: This method was utilized because of the accessibility of the population and also because it required less time to acquire the sample.
- **Quota Sampling**: The goal of quota sampling is to replicate the proportions of the subgroups present in the population. This method was used to ensure the inclusion of subject types who were likely to be underrepresented in the convenience sample, such as women who partner with other women, who remain outside the continuum of care, as well as Black/African-American women in Broward who are more likely to be diagnosed with late-stage breast cancer than White women.
- **Purposive Sampling**: This method involves the conscious selection of participants by the Community Profile team to include in the study. For instance, efforts were made to include Hispanic/Latina women living in Miami-Dade County who are considered to be linguistically isolated and are breast cancer survivors or women who partner with other women who have entered into the continuum of care.
• Snowball Sampling: This method allowed for the locating of samples that were difficult or impossible to obtain in other ways. For example, foreign-born women are a fast growing subpopulation of the US. Snowball sampling was used to select members of this group. Various community sources informed the Community Profile team that the church was an ideal setting to reach many foreign-born women, particularly Black/African-American women, because of the pre-existing connection and commitment to the church. As such, participants were contacted through word of mouth at local churches.

Based on the priority areas identified by the Quantitative Data and the Health Systems and Public Policy Analysis Reports, it was determined that the inclusion criteria would include women no younger than 20 years old and no older than 70. Because so much of the focus was on access to care and barriers, the team wanted to ensure that the individuals participating were those that were actively seeking breast health services (clinical breast exams, mammograms, diagnostic tests, treatment, follow-up care, etc.). The goal was to conduct three focus groups for each target community – linguistically isolated/foreign-born women in Miami-Dade County, Black/African-American women in Broward County, women who partner with women in Broward County and all women in Monroe County. For each target community, at least one focus group consisted of survivors and one consisted of non-diagnosed women, with the third open (i.e. could either be survivors or non-diagnosed women).

The population of interest for key informant interviews was slightly different than that of the focus groups. Because the purpose of key informant interviews was to collect information from a wide range of people who have firsthand knowledge about the community, the team agreed that non-diagnosed women would not be considered “key informants” and thus focused on breast cancer survivors instead. In addition to survivors, the team focused on securing health care providers and individuals deemed as “breast cancer advocates” who either served and/or identified with the five target communities identified by the Affiliate. The team requested that a definition for each be provided so that everyone understood who they should be targeting. For the purposes of this project, a survivor was anyone diagnosed with breast cancer, a health care provider was anyone authorized to practice medicine by the State, and an advocate was anyone who actively supports or defends the breast cancer cause. The Mission & Marketing Manager at the Affiliate was also tasked with reaching out to current and past grantees as they fell into many of these identified groups. These community experts, with their particular knowledge and understanding, were able to provide insight on the nature of problems and were able to give recommendations for solutions.

Participants excluded were women under the age of 20 years and not belonging to any of the priority groups. The goal of the team was to define inclusion and exclusion criteria prior to data collection so that the likelihood of producing reliable and reproducible results would increase the rigor of the data collection process, minimize the likelihood of causing harm to the participants, and to safeguard against exploitation of the participants, given that the majority of participants are all classified as vulnerable persons. As an incentive, participants were given gifts bags and provided with breakfast, lunch or dinner, most of which were in-kind donations.
Ethics
Each participant received a consent form outlining the focus group and key informant interview process. They were informed that their participation was voluntary and that they did not have to answer a question if they so choose. Participants also had the option to remain anonymous, though in many instances they asked not to be. For focus groups, participants completed the consent form prior to the commencement of the group. For key informant interviews, participants were provided with a consent form prior to the interview. Those who did not complete and email/fax back the form in time for the interview were asked to provide verbal consent at the beginning of the interview. In those instances the interviewer filled out a verbal consent form on their behalf, serving as the witness.

All participants were informed that the focus groups and interviews would be recorded and the process for saving those recordings. Upon completion of each focus group, Affiliate staff saved the recording on the Affiliate’s secure network in a designated folder per target community, and then uploaded to a secure site for translation and/or transcription (Gmrtranscription.com). The site was selected for various reasons: turnaround time, ease of use, cost, security of information, ability to translate from Spanish to English where necessary, etc. Transcriptions were received within 2-3 weeks, saved on the Affiliate’s secure network, as well as printed and filed away for future coding. Notes from each focus group were also saved in a similar fashion. Participants were informed of this process in the consent forms and before the commencement of each focus group.

Upon completion of each key informant interview, Affiliate staff downloaded the recorded audio files and saved them in the same fashion. Interviewers were asked to provide any notes, which were saved on the Affiliate network. The team determined that transcribing 48 interviews would be a costly endeavor, and as such, chose to have interns write summaries of each interview instead. Once all focus groups and key informant interviews were conducted, Affiliate staff provided the Data Analysis team copies for their coding and analysis.

Qualitative Data Overview

Scripts were provided for both the focus group moderator and the key informant interviewers. While the interviewers worked primarily off the script, the moderator used the script as a guide, adding to it as she saw fit. For both focus groups and interviews, notes were taken. However, these notes were not verbatim. Each key informant interview also had a summary written that was not verbatim. Only focus groups had verbatim transcripts. After each focus group, demographic data provided by participants was also input into a spreadsheet for future evaluation. The only other documents used throughout the process were focus group invitations and consent forms, both of which were translated when needed.

The team agreed that though the timeframe to analyze the data was going to be constrained, a data management method tool package was not cost effective and so chose not to go that route.
Four data sources were selected for the qualitative assessment of this report. These sources were linguistically isolated or foreign-born women in Miami-Dade County, Black/African-American women in Broward County, women that partner with other women in Broward County and women in Monroe County. This office referenced the Quantitative Data Report for the Miami-Dade/Ft. Lauderdale region prepared by the Komen National Office and its Health Systems Analyses Report to select the priority areas and data sources for this qualitative assessment. Collectively, the conclusions made in these reports suggested that while breast cancer incidence and death has improved overall in this region, particularly in Miami-Dade County, distinct disparities still remain within each of the three counties regarding access to diagnostic and treatment services and survival support for these data sources.

Disparities were most evident between two distinct groups. The first group being the linguistically isolated women in Miami-Dade County who were foreign-born and newly immigrated into the United States. These women remain outside the local continuum of care for many reasons including inability to communicate with providers, fear of discovering breast cancer, cultural norms that do not promote health prevention activities, immigration status, and lack of education about breast cancer prevention. These factors have contributed to the large number of Hispanic/Latina and Haitian women that are isolated from the continuum of care. This sample was comprised of women currently living in Miami-Dade, between the ages of 20 and 70, self-identified as foreign-born who had immigrated to the US, and English was not the primary language spoken in their home.

The second source represents Black/African-American women within Broward County that remain outside the continuum of care. In Broward, Black/African-American women are more likely to be diagnosed with late-stage breast cancer than White women. In fact, particular segments of this county have rates of late-stage diagnoses that not only exceed other regions of the county, but also that of state and national rates. For these reasons, Black/African-American women living in Broward County became the second priority area for the qualitative assessment. Women included in this sample were between the ages of 20 and 70, self-identified as Black/African-American and currently reside in Broward County.

The third source was suggested from an informal assessment of the service gap report where the Affiliate’s Executive Director noted a lack of service options for women who partner with other women. This discovery supports the anecdotal comments made by community members to the Affiliate regarding the lack of culturally and socially sensitive services for this demographic. Prior research in the area of public health has shown that being LGBTQ has served as a barrier to many women regarding access and use of health care services. The Affiliate acknowledges that it has not formally collected information on this topic. It therefore has selected this as an opportunity to improve its capacity to meet the needs of women within the LGBTQ demographic in Broward. Women in this sample disclosed that they were LGBTQ, and currently living in Broward County.

The final source was selected because of the unique challenges faced in Monroe County related to access, treatment and survival. These challenges are due to a combined effect of
coverage across multiple islands and scarce local health-related resources. Residents often commute to mainland for health care services. Both the health services report and the quantitative data indicate that many areas in this region lack resources to support screening and treatment for breast cancer. Thus, the Affiliate used the focus groups as an opportunity to document the experience of women as they related to engaging in the health care system.

There are several approaches to the analysis of qualitative data. For the Affiliate purposes, framework analysis (Krueger, 1994; Ritchie & Spencer, 1994) was utilized. The first step involved becoming familiar with the data. This was done by two members of the group (one was the moderator for the focus groups) reading the transcripts in their entirety several times and summary notes immediately after the tapes were transcribed by a third party. The aim was for the team members to immerse themselves in the details and get a sense of the interviews as a whole. The next step involved identifying a thematic framework by writing memos such as short phrases, ideas or concepts arising from the text and forming descriptive statements. The third step involved highlighting and sorting out quotes and making comparisons both within and between questions and groups. The fourth step, involved lifting the quotes from their original context and re-arranging under newly developed thematic content. The final step is the interpretation of the data. This step involved making sense of the individual quotes by imaginatively and analytically being able to see the relationship between the quotes and the link between the data as a whole.

A total of 10 focus groups and 24 key informant interviews were held across the three regions within this catchment area. Three of these sessions addressed issues concerning women that lived in Miami-Dade County who were linguistically isolated or foreign-born. Three sessions addressed issues concerning Black/African-American women who lived in Broward County. Three sessions were conducted in Monroe County and addressed issues women faced to access the continuum of care within such a geographically disperse area. The final session was also held in Broward and addressed the issues faced by women who partner other women as it related to being engaged in the continuum of care.

The next section describes the main themes arrived at from the data collected in focus groups and key informant interviews.

Linguistically isolated/foreign-born women in Miami-Dade County

Lack of breast health awareness for newer immigrants

Within this group there seemed to be a divide between those women who are foreign-born but have been in this country for a length of time and those who arrived more recently. The first group seemed to have a clear idea of where to get breast health information and services, whereas the newer immigrants were not even aware that breast screenings were the norm, much less where to get the information and screening done. In one focus group comprised mostly of women new to the country, only one woman had had a breast exam in her lifetime and then only because she had another ailment and was sent for a full check-up. These same women, when asked where they thought they could get these services, explained that clinics did not exist in their community. When they were told that there were in fact free clinics readily
accessible, they explained that because they were not aware of them, the perception is that they are not there. When asked how this information could be disseminated, many felt that going to schools where immigrants are taught English would be a good place to start, while others thought that going to churches, where there’s an established women’s group, would be a good option. On a positive note, many foreign-born women explained that receiving information/services in their native language was not an issue as most medical institutions have translators readily available.

Key informants in Miami-Dade County felt that unlike other communities where there is a lack of medical resources, Miami-Dade does not have to worry about that. The worry here is a lack of education and health literacy. Providers, she urged, need to do more because the resources exist but people just don’t know where to find them. One provider disagreed with feedback from focus groups regarding language not being a barrier, saying this may be true for Hispanic/Latina populations, but not Haitian/Creole speaking populations as there is still a critical need for translators there.

**Differing cultural norms**

Every immigrant group brings a variety of cultural attitudes towards health, health care and illness, and within each of these groups there are varying health and illness beliefs and practices. Exposure or touching of the breast is a private and personal experience that many Hispanic/Latina and Caribbean women may not engage in due to cultural dictates. Therefore, clinical breast exams in the US run contrary to what many linguistically isolated and/or foreign-born women have been raised to understand as a culturally or socially accepted behavior. Having a breast examination was not normally practiced in the host countries. Many foreign-born women, also divulged that speaking about cancer was not only against cultural norms, but taboo in their host country. Many explained that family customs were such that if your mother or female relatives had breast cancer, you may never find out because it was a private matter. While others said that because their female family members did not get screened at all while they were growing up, they didn’t get screened either once they entered adulthood and/or came to this country. Many of these practices within the concept of preventative medicine are more of a westernized practice. Therefore, being aware of the benefits to practicing breast self-awareness, including mammograms and clinical exams are not a common part of the health practice. Key informants mirrored these sentiments as well.

**Undocumented status**

Miami-Dade County is home to a large immigrant population, many of which are undocumented and in the country illegally. For those women represented in these groups, there is an obvious fear of being deported and as such they avoid seeking medical care of any kind. While some of these women are aware that free clinics may assist them without requesting their legal status, they are often still hesitant to go because free clinics require so much paperwork to qualify for free services. One explained that the first question free clinics ask is what your social security number is, and when you’re undocumented that is alarming. Another immigrant, who has recently become a citizen, says she doesn’t want to be a burden to this county so she avoids asking for financial help of any kind, even for medical care.
Key informants had a lot to say when it came to undocumented populations in Miami-Dade. Most providers felt that immigration status was a true challenge because undocumented women feel like there is no place for them to go and worry that if they get treatment, and disclose their illegal status, they will be deported. This sentiment mirrored that of the focus groups. One free clinic, which sees undocumented populations, agreed with the data collected in the focus groups, saying that there is too much paper work for undocumented patients to get help, the system becomes a burden to them, and often the requirements are too high for free service. Added to that, many organizations won’t even offer services to those that are undocumented, creating yet another barrier.

**Lack of insurance and/or financial resources**

The overarching theme that came up as it related to seeking breast screening services in Miami-Dade was a lack of resources to pay for the services (i.e., insurance, money). Many of the women participating shared the feeling that if you have insurance or money, then you’re okay. Those that did not, explained that when calling or visiting doctors, this is often the first question they ask, which can be very off putting for someone lacking these resources. Others explained that medical bills seemed to be never ending. Even those women with insurance were often surprised to find additional bills beyond what their insurance covered. Because breast health services are often performed by specialists, who cost more, many of the women explained that this is why they avoid getting their screenings done. While others explained that even when working 16-18 hour days, their financial situation was tight, and caring for their kids and their needs was more of a priority than caring for themselves.

When speaking to key informants in Miami-Dade, providers agreed that cost of care and lack of insurance is always a factor with foreign-born/linguistically isolated populations. For many of these women, getting medical care often battles with having a roof over their head and food on the table, which often win out. And because doctor appointments are usually during working hours, they have to risk losing their job or missing out on pay to go to the doctor, often resulting in patients not seeking care and finding out about health issues when they are late-stage. As one provider pointed out, “health is not their priority, for many it doesn’t even register as a concern.” Providers also spoke candidly about the lack of services for the uninsured, saying that while screening options are often available for free or reduced prices, if a woman is diagnosed with breast cancer and has no insurance, she has very few places to turn.

**Lack of additional resources**

Other secondary obstacles seem to come up in conversation regularly among this group, such as a lack of consistent transportation and child care, limiting a woman’s ability to get screened and/or get the care needed. However, the groups served as a great forum to share resources and many did. One group explained that not only does Jackson Memorial Hospital assist with transportation if you are receiving treatment there, but the county also has a free transportation program to transport women to/from treatment. Those women who were not lacking these resources expressed different needs altogether – help with housework such as cooking and cleaning, which can be difficult after surgery, services for family members going through the
process with them, classes on how to care for yourself after surgery/treatment, etc. A lot of 
these women sang the praises of support groups and the importance of breast cancer survivors 
finding a support system. For many survivors, support groups proved to be an invaluable 
support system where they could let go of the negativity and focus on being optimistic about 
their cancer journey.

**Black/African-American Women in Broward County**

**Competing priorities**

Overall, Black/African-American women in Broward had several competing priorities that often 
prevented their engagement with the health care system as well as interfered with their ability to 
screen and to consistently obtain breast cancer treatment services. Primarily Black/African-
American women were faced with more urgent issues that detracted from their focus on 
treatment. Many of the women described how they were struggling to deal with many other 
health conditions such as diabetes. These immediate issues in their lives took precedence over 
breast cancer screening and treatment for breast cancer. In each session, women 
acknowledged that immediate personal issues and management of other comorbidities took 
priority.

**Fear and stigma are culturally relevant**

For Black/African-American women there can be a culture of silence about breast cancer. This 
lack of communication is the result of a lack of education in the community about cancer and the 
role of screening to prevent breast cancer risk. The lack of communication is also tied to cultural 
stigma about cancer. There is also an underlying fear for some women about discovering they 
have developed cancer which can delay screening. Each is a health detriment that can delay or 
prevent engagement with the continuum of care.

**Lack of insurance and/or financial resources**

In addition to health-related concerns, these women described their struggles with financing the 
cost of breast cancer screening and cancer treatment. The majority of the women had become 
insured under the Affordable Care Act and had attempted to use this resource for their care. 
Despite having insurance, many of the women have been denied care or turned away from care 
because their insurance is not accepted. The perception being left in the community by this is 
“we don’t want you, we don’t take that.” A few of the women described how resources are 
disappearing in that doctors are electing not to accept insurance plans issued under ACA. This 
position taken by doctors continues to leave these women without the necessary resources to 
screen. The women have turned to mediating agencies to address these concerns. Many of 
these 501(c)3 organizations educate the community and help to levy resources for women in 
need. These organizations also act as advocacy entities for women who are disenfranchised 
and unsure where to go, what to do and how to care for themselves as it relates to breast 
cancer.

**Universal unawareness and outreach efforts**

There is a universal unawareness of available resources in the community. Those resources 
that are available are not prominent and they remain not well marketed. The participants felt
that the discussion should begin by addressing how Black/African-American women in Broward access information. Initially, there is a pervasive lack of awareness about breast cancer in the community. If women do not understand the risk and nature of the disease, they will not know what health information they need. This means that primary education on breast health and breast cancer has to happen before the information on screening will be effectively received. There are two choices for these women to access cancer screening, treatment and survival information. These choices can be characterized as medical (provider) or non-medical personal relationships such as a mediating agency. The primary need for the women is the ability to navigate through the medical establishment and to navigate through the social stumbling blocks within the community. The other choice presented to the women is to coordinate their health without the assistance of a third-party entity. For those who chose the latter, they felt lost and unsuccessfully navigated the system. Better communication of available resources and services needs to be a priority for this community. Communication about breast cancer screening and services should be an ongoing occurrence. Outreach should use several approaches including word of mouth, social media, ad campaigns, messaging in churches, and engagement of unconventional sites such as local social networks.

**Trust in the health care system and its effect on perceived quality of care**

The women were divided on the issue of trust. There appeared to be an association between trust and the perceived quality of their experience with the system. Those women that trusted the system did so because their experience included an open dialogue, and they approved of the treatment and interaction they had with health care employees. For those that did not trust the system, the lack of trust was associated with being an insider (i.e. health care worker) and seeing firsthand what happens within the system or receiving poor quality of care as a patient. The primary themes associated with lack of trust include: role of insurance companies to protect costs at the expense of caring for patients; continued disparities among the poor and communities of color; lack of education hindering women from recognizing or demanding quality care; and breakdown in the system.

**Women who partner with women in Broward County**

**Fear**

Many of the women participating in this focus group explained that their sexual orientation was not really an issue when it came to receiving medical services. The consensus among the group was that most often medical professionals do not ask for this type of disclosure and as such oftentimes do not know that they are a part of the LGBTQ community. Many of the women felt that health care professionals have made great strides as it relates to the gay community. One participant even went so far as to say “being gay has nothing to do with it,” when talking about the quality of care received. Perhaps more pressing in this group was a general fear of the unknowns of breast cancer, a feeling that breast cancer happens to other people, not me. This exists regardless of their sexual orientation. One woman explained that for women their breasts are such a definitive part of their womanhood that the thought of exposing their breasts feels threatening. Another participant, who works in the health care field, when following up with a patient who she sent for a mammogram and hearing her story of the experience apologized for putting her through it.
**Need for cultural competency training for health care professionals**

When speaking to key informants, particularly health care providers, the consensus appeared to be that many do not require that patients disclose their sexual orientation, and therefore, cannot speak to the specific problems this population faces. In fact, this fact proved to be a problem when trying to coordinate focus groups comprised of women who partner with women. So few organizations had this information on file that it was not possible to get more than one group to participate. One provider did speak of the need for cultural competency training for medical professionals working with the LGBTQ community. In talks with community partners who serve this community, they shared these sentiments saying that there exists a lack of sensitivity among health care providers when it comes to working with the LGBTQ community.

**Women in Monroe County**

**Rural nature of Monroe County**

Unlike the other counties in the service area, Monroe County is rural in nature. A rural county is defined in terms of the geographic location and population density as well as the distance needed to commute to an urban center. The women who live in the Lower Keys felt that having to travel great distances to urban areas may deter some women from seeking help. If there was no personal frame of reference (i.e. knowing a survivor who could recommend a trusted health care provider), the women remained frustrated with the care they received in Monroe County, and often traveled to Miami-Dade County for care. The participants’ responses suggested that the residents perceive that all is better in a more urban city like Miami than in the island system of Monroe. They see that the array of services offered in Monroe are limited compared to those on the mainland. Collectively, these perceptions create fear about the integrity and competency of the local care system (discussed below).

Key informants agreed that there is a shortage of providers in Monroe County, causing many residents to travel to get services. The consensus among this group is that there is good support at the screening stage, but if something is diagnosed, the resources run out and there is nowhere to go locally for support.

**Breast health info not sufficient and often confusing**

Many of the women participating in the Monroe County focus groups disclosed that they had no idea where to find breast health information or the subsequent resources/services. Others admitted to being confused with all of the conflicting breast health messages out there, as it relates to what age to get screened, what screenings are best, etc. In many instances, misleading information discouraged these women from seeking out care in the first place. For those who did, conflicting messages became a barrier to remaining in care and continuing with follow-up services. Those women who had had positive experiences explained that in those instances where the information provided was clear and convincing, their trust in the process was stronger and they were more likely to follow through with the recommendations of the physician. Unique in this community, that describes itself as grassroots and close-knit, is that because they are relatively small, residents tend to get their information in a few common ways. The women unanimously agreed that making breast health and/or screening information available in their local paper(s) as well as local social media sites would be a tremendous help.
Others recommended going through the church and school bulletins/newsletters, radio shows and health fairs.

**Trust in the health care system and its effect on perceived quality of care**

Most of the women participating expressed a lack of trust in the local medical community that stemmed from a lack of reliable medical resources locally. The consensus among the group was that while basic screening options are available, if a woman is diagnosed with breast cancer, treatment is not readily available in Monroe County. Many expressed that medical groups there are full service for other health issues, but not breast cancer and so the assumption is that if you are diagnosed with breast cancer you will have to go elsewhere, most notably Miami-Dade, for treatment. Some women went so far as to say that if there was something seriously wrong, they would definitely leave, while another mentioned that the older she gets the more she considers giving up island living for one with reliable medical care. A few women, who cannot afford to leave Monroe County for medical care, expressed that though they were hesitant at first, they grew to trust their team of doctors/nurses. One even felt that the quality of care she received was better because the doctors are in less of a hurry there. However, overall, the consensus among the group was that if they discovered a suspicious finding when getting a screening, these women would go to Miami-Dade for further treatment, not only because the treatment options are available but because they have specialized breast centers that are dedicated to these issues. These women want the best of the best and someone who deals with breast issues every day, not just once in a while.

**Lack of insurance and/or financial resources**

As with most other groups surveyed, there was a common theme of a lack of insurance and/or money among this group. Many women in Monroe County expressed that the cost of screenings was prohibitive when you do not have insurance. Many explained that their doctor was “the emergency room,” and that because they did not have insurance they did not have the luxury of preventative care. Even those with insurance explained that for the middle class it can be a hardship because they don’t qualify for the charity dollars that go to the unemployed/uninsured, but they can’t afford to pay the out of pocket fees either.

Key informants agreed that the entire county suffers from being underinsured, and lacking the financial resources to follow through with care. This impacts patients’ transition from screening and diagnosis to treatment. A concern was also expressed that financial assistance is available for screenings, but not next steps, which is yet another barrier.

Fear of the unknown was a common theme among all priority groups that emerged from the data. Fear of the unknown appears to be a constant theme irrespective of the women’s cultural, social, sexual or economic backgrounds. Despite many inroads in breast cancer screening, there is evidence to suggest that a large proportion of women are not seeking screening at nationally recommended rates (U.S. Department of Health and Human Services). Breast cancer continues to carry with it a great deal of stigma within all communities, and this stigma produces a culture of silence about the disease, which in turn causes fear of the unknown about the disease. The participants highlighted the absence of an ongoing dialogue about cancer as the
primary issue within the community. This includes the lack of communication about the disease and the need to create an open dialogue throughout the community about the disease. Such communication will help to dispel the fear about breast cancer among the women and improve the sharing that needs to happen between men and women about the disease.

**Qualitative Data Findings**

The questions that were asked of participants were selected based upon the contextual nuances documented in the Quantitative and Health Systems and Public Policy Analysis reports. These reports offered a visual representation of the available services throughout the regional area, and documented the gaps of services and proximity of these resources to the breast cancer hot spots in the region. The Affiliate is now equipped with the information to document the existence of breast cancer related programs by county and the nature of the services offered regionally. The qualitative analysis builds yet again on the previous reports by presenting the community perspective on how effective these services are when it comes to meeting the needs of the women in the region. Collectively, these reports map the services offered in the region and the extent that the services meet the needs of the women to successfully screen, treat, and overcome breast cancer.

In qualitative design, the goal is to understand the participants’ points of view and to be able to communicate these to an audience. Focus groups as a methodology allowed for interaction between the moderator and the group as well as interaction between group members. The interaction between the groups was clearly a strength that was evident throughout this process. The focus groups allowed for the sharing of information between group members as well as many of the groups acknowledged the need to form their own support groups. Utilizing focus groups gave the Affiliate the opportunity to explore new ideas by obtaining in-depth information regarding how women think about breast cancer and the services available.

**Limitations of the Qualitative Data**

Data collection proved to be a challenge. Although the team was able to identify the necessary number of focus groups for the first three priority groups (linguistically isolated and/or foreign-born women in Miami-Dade County, Black/African-American women in Broward County and women in Monroe County), the same could not be said for the final group – women who partner with women. After several attempts at reaching out to various community partners, the team was only able to complete one focus group for this population. Community partners were not at all surprised by this limitation, as they said sexual orientation was not a question they asked of their participants and as such it would be difficult for them to gather a group based on that requirement alone. The same challenges existed for key informant interviews. Because many key informants were professionals in the medical profession, it was difficult for these potential key informants to indicate a time that they were available. After numerous attempts only 27 of the 48 key informant interviews were completed (eight for linguistically isolated/foreign-born women in Miami-Dade County; 10 for Black/African-American women in Broward County; two for women who partner with women in Broward County and seven for women in Monroe County). As with focus groups, the group that proved to be the most difficult to reach was
women who partner with women. Only two key informant interviews were completed among health care providers who service these women. Another weakness/challenge was that analysis was time-consuming given the enormous amount of raw data collected. Due to the small sample size and the methods of sampling used, the ability to generalize the findings to the entire target communities was limited.

Conclusions
In conclusion, several important findings have been uncovered in this process as well several consistent themes that resonated across all priority groups. All groups expressed that fear and cultural behavior is a barrier to obtaining breast health services. With the exception of the women who partner with women in Broward County, all groups touched upon the lack of insurance or financial resources for breast health services and treatment. While the Affordable Care Act has allowed more people the ability to enroll in affordable health insurance coverage, many of these plans are not being accepted by health care providers. This leaves a gap in services by reducing the number of providers available and over booking of the providers that do accept these policies, lengthening the time to get appointments for breast health services and treatment. More importantly, it leaves those attempting to find breast health services feeling frustrated and unwanted by the health care community. This may delay their efforts to get screened or receive needed treatments due to the effort needed to find a provider to accept their insurance or an alternative financial resource. Another common theme was the lack of or perceived lack of breast health information and resources for all groups.

For the linguistically isolated/foreign-born women in Miami-Dade County, several key themes emerged. The qualitative findings suggest that in some cases, individuals who speak Spanish as a first language did not consider language to be a barrier because Miami-Dade has such cultural diversity that Spanish speakers are readily found in most health care institutions. The more recently arrived foreign-born women were less aware of breast health services available and the entire group felt there were lingering cultural barriers to overcome in discussing or accessing breast health services. Many of these immigrants are also undocumented and face the threat and fear of deportation if they access needed services. There are only a few health care providers that service the undocumented population.

Black/African-American women in Broward County felt that competing priorities was a difficult barrier to overcome. For these women, the needs of their children and families and financial struggles were their first priority. Trust in the health care system was a barrier for both Black/African-American women in Broward and women in Monroe County. Some of the mistrust was from women who work in the health care field and see examples of incompetence and lack of concern on a daily basis. Surprisingly, the findings suggest that for Monroe County, the overarching issue isn’t the distance needed to travel to procure breast health care services, as the Affiliate thought, but more importantly, the lack of confidence in the quality of the services available locally. This could stem from the smaller amount of breast health service providers which reduce the number of choices available.
Perhaps the most troubling finding the Affiliate came across was the difficulty in gathering data on women who partner with women, which is an Affiliate priority in Broward County. As the Affiliate discovered, sexual orientation is not as easily identifiable as other factors, and often times, it is taboo to ask a patient to self-disclose this information. Education on cultural competency for providers is urgently needed. With the new same sex marriage law enacted for the state of Florida, there is hope that adding additional questions to the intake forms of providers will help identify and communicate breast health information to this population. It is evident that additional efforts need to be expended to ensure that this segment of the population has the resources and education available to make informed decisions on their health care options.
Breast Health and Breast Cancer Findings of the Target Communities

Summary of the findings from the Quantitative Data Report and how the findings led to the selection of the target community

The findings from the Quantitative Data Report that were reviewed and analyzed by Susan G. Komen Miami/Ft. Lauderdale were geared toward making the service area compliant with the Healthy People 2020 initiative. Healthy People 2020 is a major federal government initiative that provides specific health objectives for communities and the country as a whole. The Affiliate analyzed the statistics provided for the service area and identified areas of priority based on the time needed to meet Healthy People 2020 targets for breast cancer as well as other local priorities based on community knowledge not included in the statistics or data given in the Quantitative Data Report.

The selected target communities are:
- Broward County: Black/African-American females and women who partner with women
- Monroe County
- Miami/Dade County: Women who are linguistically isolated/foreign born

Broward County
Broward County has a Medium High Needs / priority classification based on the projected time of 13 years or longer to meet the Healthy People 2020 target goal for late-stage incidence and 0-6 years to meet the death rate target goal.

This county has a substantially higher Black/African-American female population than the other two counties in the service area with a slightly higher percentage of residents who are unemployed. While the Affiliate service area as a whole has a substantially higher percentage of the population age 40-64 living without health insurance (32.6 percent), Broward County has a substantially larger percentage of this population without health insurance than the United States average of 16.6 percent.

Data is limited on women who partner with women, however, according to the Williams Institute Florida Census Snapshot of 2010, Broward County ranks number two in the state in same sex couples with an estimated 11.33 per 1,000 households. Broward County also has three out of the top four cities in the state rankings of highest percentage of same sex couples per 1,000 households. Women who partner with women are believed to have a higher risk of breast cancer than other women because they usually have more risk factors. They are less likely to bear children or to have children earlier in life. Obesity and alcohol use rates are also higher among women who partner with women.

Miami-Dade County
Miami-Dade County is the most populous county in the Komen Miami / Ft. Lauderdale service area hosting over half of the service area population. Miami-Dade County currently meets the
Healthy People 2020 breast cancer death rate target and was projected to meet the late-stage incidence target goal in two years.

The demographics of Miami-Dade County per Table 4 show that 65 percent of the residents are Hispanic/Latina (vs. the national average of 16.2 percent), with 51.2 percent being foreign born (vs. 12.8 percent nationally) and 26.7 percent being linguistically isolated (vs. 4.7 percent nationally).

With 51.2 percent of the Miami-Dade County population being foreign born and 26.7 percent being linguistically isolated it is imperative that Komen Miami / Ft. Lauderdale continue to search for ways to impart breast health information and materials that communicate in the various languages and learning styles of this demographic and to insure that these different methods result in a continued improvement in the Healthy People 2020 Breast Cancer Initiative.

**Monroe County**

Monroe County has a Medium Needs / priority classification based on the projected time of 13 years or longer to meet the Healthy People 2020 death rate target goal while it currently meets the Healthy People 2020 late-stage incidence target goal. Monroe County is the southernmost county in Florida and the United States. The most well-known part of Monroe County is the Florida Keys, a chain of low lying islands connected to the mainland by U.S. Highway 1, which ends 150 miles south of Miami in Key West. Due to the geographical layout of Monroe County medical access is limited with 100 percent of the population listed as living in medically underserved areas and 8.7 percent in rural areas per Table 2.5. The female population of Monroe County is substantially older than the United States average in both the categories of 40 plus (59.8 percent vs 48.3 percent) and 50 plus (44.5 percent vs 34.5 percent) with a slight increase in average for the 65 plus category (17.5 percent vs 14.8 percent).

Monroe County has a death rate and trend of 25.1 per 100,000 which is substantially higher than the Healthy People 2020 rate of 20.6 per 100,000 as well as the Komen Miami / Ft. Lauderdale service area rate of 21.1 per 100,000.

The data were suppressed due to small numbers (fewer than 10 samples) on the proportion of women ages 50-74 with screening mammography in the last two years who self-reported in Monroe County.

**Summary of the findings from the Health Systems and Public Policy Analysis related to the target communities and key questions identified by the Quantitative Data Report**

**Broward County**

The number and location of hospital systems located in Broward County is an obvious strength of the community. The 17 hospitals seem to be readily accessible from all parts of Broward, and provide the full continuum of care as it relates to breast health services. While there are several hospitals located in or near critical needs areas, there appears to be a shortage in patient navigation services which would help ensure that patients are following through with care and

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not getting lost in the continuum of care. All health centers listed provide breast screening services, while 73 percent provide diagnostics tests, 34 percent provide treatment options, and 39 percent provide supportive services such as financial assistance, survivorship services, legal advice, etc. While only four free clinics are listed, the majority of the hospitals provide free or low-cost services, and there is a plethora of community health centers throughout the county, ensuring that those patients lacking insurance and/or financial resources have somewhere to turn.

Susan G. Komen Miami/Ft. Lauderdale currently partners with more than 20 organizations within Broward County that provide breast health services to the target communities. However, there are several organizations and hospitals, including those in predominantly underserved communities that the Affiliate strives to partner with in the future to ensure that the needs of the entire community are met.

As it relates to women who partner with women, the second target community in Broward County, geographically the support systems appear to be in place. Broward County is home to three of the top four cities in the state with the highest percentage of same sex couples. Two of these cities have hospitals within the city, and the third has one within five minutes of the city limits. Additionally, the Affiliate needs to take a close look at how this population is being served and what issues may exist that prevent them from receiving adequate health care. A partnership needs to be established between the Affiliate and groups that work with the LGBT community so as to ensure that this happens.

**Miami-Dade County**

Miami-Dade County has 20 hospitals that are geographically spread throughout the county. An additional 20 free clinics and countless community health centers offer services throughout the county. There appears to be an abundance of health resources in Miami-Dade, with 93 percent providing breast health screenings, 61 percent providing diagnostic tests, 17 percent providing treatment options, and 22 percent providing supportive services. The presence of free clinics is particularly important because Miami-Dade County is home to a large immigrant population, which often has to turn to free clinics to receive services. The only area that appears to be slightly lacking in service is South Miami-Dade, near Homestead, where it appears one hospital, one free clinic and few health centers are located. However, both the East and West side of Miami-Dade are well represented.

The Affiliate currently partners with more than 20 organizations within Miami-Dade County that provide breast health services to linguistically isolated/foreign-born women. There are two hospitals on the east side of the county, as well as other community health centers that the Affiliate has never partnered with and hopes to in the future. There are also several hospitals within Miami-Dade that are currently building new Cancer Institutes, and the Affiliates has begun discussions on ways to partner in the future.
Monroe County

With Monroe County comprised of three main segments, access to health care services is very limited. While there appears to be at least one hospital and one community health center serving each geographical section of Monroe, the bulk of the health centers, including all the free clinics in the county, are located in Key West. This can mean up to a three hour drive for those living in the Upper Keys. Similar to Miami-Dade and Broward, where the majority of the health centers provide screening services, 86 percent of health centers in Monroe County do so, while only 27 percent providing diagnostic tests, 18 percent providing treatment options and 32 percent providing supportive services. These numbers are much lower than the rest of the service area. As such, providing easy access to the full continuum of care is a major concern of the Affiliate.

Currently, Susan G. Komen Miami/Ft. Lauderdale partners with two health centers in Monroe County. The Affiliate is actively looking for additional health organizations with which to partner in the future, in an effort to help increase breast health services to the community and provide easier access to these services. Additionally, Komen Miami/Ft. Lauderdale is looking to host more outreach activities in the area to increase awareness of Komen and breast cancer.

Summary of the findings from the Qualitative Data relating to the target communities and key questions

The Qualitative Data findings revealed that when seeking out and/or following through with breast health care, lack of insurance and/or financial resources was a common problem among women in the entire service area. For many women, their health didn’t seem to register as a priority, especially when compared to other necessities such as paying the rent, putting food on the table, and caring for their children. The added stress of missing work, oftentimes without pay, just to go to the doctor was a deterrent to getting screened and following through with care. Lack of insurance also seemed to play a huge role in whether women were regularly screened. Many women explained that their doctor was the “emergency room” because they simply could not afford the luxury of preventative care. Even those who had recently become insured under the Affordable Care Act (ACA) reported being denied care because their insurance was not accepted in many health care facilities.

Fear of the unknown was also a common theme among women in all three counties. The women participating in focus groups expressed a number of reasons for this phenomenon. For many linguistically isolated/foreign-born women, the concept of cancer was taboo and often not spoken about in their host countries. Added to that, exposure or touching of the breast is considered a private and personal experience among many in this group, therefore, clinical breast exams were not the norm for these women. These sentiments were also mirrored in conversations with women who partner with women and Black/African-American women in Broward County. In most groups, the participants felt that there was a clear absence of dialogue about cancer within their community, which created a great deal of stigma and ultimately a culture of silence about the disease.
There also appeared to be a lack of breast health awareness among women in all three counties. Many of the women surveyed did not know how often they should be getting their breast health screenings nor where to get them done. The perception among this group was that the resources did not exist in the community, and while that is true in Monroe County, in both Broward and Miami-Dade the reality was that they just weren’t aware of them. When asked how/where to disseminate this information, the responses were as unique as the groups themselves, however, the consensus was that communication about breast health services needs to be an ongoing occurrence among these communities.

Additional issues specific to each target community also arose from both the focus groups and the key informant interviews. In Miami-Dade County, one of the main issues centers around the large immigrant population, which is often undocumented. For these women, seeking services comes with an inherent fear of being deported. Added to that, the paperwork and requirements necessary to receive free services when undocumented is often so cumbersome that the system itself becomes a burden. But perhaps most pressing of all for this group, is that so few health centers offer services for undocumented women, creating yet another barrier to receiving care.

In Broward County, when surveying women who partner with women and key informants that serve that community, it was evident that there is a need for cultural competency training for health care professionals. Many organizations do not require women to disclose their sexual orientation, which limits their ability to speak to the specific needs of these women. Overall, there appears to be a lack of sensitivity among health care providers when it comes to working with the LGBT community, which clearly needs to be addressed.

Monroe County had a host of other issues unique to their community. First and foremost, the rural nature of their community requires many women to have to commute long distances to receive breast health services. Added to this is an obvious shortage of health care providers offering breast health diagnostic and treatment options to women in Monroe County. The consensus among women and key informants was that there was good support at the screening stage, but that once an abnormal finding occurs women must travel to more urban cities like Miami to receive the necessary diagnostics/treatments. As a result of the lack of resources and subsequent need to travel elsewhere for services, these women exhibit fear and lack of trust in the local health care system.

**Mission Action Plan**

**Broward County**

**Problem Statement:** For the Affiliate as whole, both the late-stage incidence rate and death rate are higher among Black/African-American women than White women, and Broward County, in particular, is home to a relatively large Black/African-American population. The health system analysis found that breast cancer screening, diagnostics and treatment options are readily available throughout the county. However, breast cancer survivors and health care providers indicated that among the Black/African-American population there is a universal unawareness of
breast cancer and the available breast health resources in the community. If women do not understand the risk and nature of the disease, they will not know what health information and/or services to seek out.

**Priority:** Provide education on breast health and available resources to Black/African-American women in Broward County, so as to ensure that screening information and practices will not only be effectively received, but also acted upon.

**Objectives**
- In FY16, meet with service providers in Broward County that work with the Black/African-American community to develop an action plan on how to improve breast cancer outreach and education in this target community.
- By 2017, update Affiliate RFA to include outreach requirements for anyone serving the Black/African-American community in Broward County.

**Problem Statement:** Very little statistical data on women who partner with women is available. However, because women who partner with women are less likely to bear children and exhibit riskier lifestyle choices such as alcohol use and obesity, they are believed to have more risk factors for breast cancer than other women. Broward County ranks second in the state in same sex couples, and is home to three of the top four cities in the state with the highest percentage of same sex couples. According to the health system analysis, two of these cities have hospitals within the city, and the third has one within five minutes of the city limits. Community partners felt that geographically the services are in place, but that there is a lack of sensitivity among health care providers when it comes to working with the LGBT community.

**Priority:** Provide cultural competency training for health care providers and staff working with the LGBT community in Broward County.

**Objectives**
- By 2016, meet with key LGBT community leaders to determine best practices that should be put in place in all health care facilities serving the LGBT community in Broward County.
- By 2017, fund a cultural competency “train the trainer” program to be disseminated to all providers serving the LGBT community in Broward County.

**Miami-Dade County**

**Problem Statement:** In the target community of Miami-Dade, 65.0 percent of the residents are Hispanic/Latina, while another large percentage are Haitian/Caribbean. Of that number, 51.2 percent are foreign-born and 26.7 percent are linguistically isolated, both of which are significantly higher than the national average. Statistics show that Hispanics/Latinas tend to be diagnosed with late-stage breast cancers more often than Whites. Due to cultural norms and language barriers, the Haitian/Caribbean population faces high late-stage diagnosis rates as well. The health system analysis indicated that there is an abundance of health centers
throughout Miami-Dade County, including free clinics which are particularly important in this population, with a vast majority of them providing screening and diagnostic services. However, women in the community could not readily identify where to get free/low-cost services, while providers expressed that unlike other communities where medical resources are lacking, in Miami-Dade it is education and health literacy that are lacking.

**Priority:** Increase breast health outreach to foreign-born/linguistically isolated communities in Miami-Dade County.

**Objectives**
- In FY16, meet with service providers in Miami-Dade County that work with linguistically isolated/foreign-born women to develop an action plan on how to improve breast cancer outreach in this target community.
- By 2017, update Affiliate RFA to include outreach requirements for anyone serving linguistically isolated/foreign-born women in Miami-Dade County.

**Problem Statement:** Miami-Dade has a large population of undocumented women, who are not accounted for in the Census data due to their illegal immigrant status. These women, who are most often Hispanic/Latina and/or Caribbean/Black, both have higher late-stage incidence rates than White women. The health system analysis found that the health systems exist in the community; however, there is a shortage of centers in South Miami-Dade, where a large immigrant population resides. Women in the community and health care providers indicated that immigration status was a true challenge because undocumented women feel like there is no place to go, and worry that if they disclose their illegal status they will be deported. Added to that, with the abundance of paperwork required at free clinics, the system becomes a burden to them, oftentimes making the requirements for free service too cumbersome.

**Priority:** Identify health care providers in Miami-Dade County that offer services to women regardless of immigration status, and work on streamlining both the communication of these services and the registration process to receive services.

**Objectives**
- By 2017, develop new collaborative relationships with local groups (i.e. embassies, consulates, immigration groups, etc.) who work with the undocumented population of Miami-Dade County.
- By 2017, survey community health centers in Miami-Dade County to establish resource list for undocumented patients.

**Monroe County**

**Problem Statement:** In the target community of Monroe County, the death rate is higher than both the Affiliate as a whole and the state. Due to its geographical layout, 100.0 percent of the population is listed as living in medically underserved areas. Monroe also has a higher percentage of residents living with no health insurance when compared to the national average. The health system analysis revealed that the county as a whole is severely lacking in medical
resources. Though there appears to be one hospital in each segment of the county, the bulk of
the health centers and free clinics are in the Lower Keys, which would mean a three hour drive
for those living in the Upper Keys. Of the small number of centers that do exist, only 27.0
percent provide diagnostic services and 18.0 percent provide treatment. Survivors and providers
alike felt that there is good support at the screening stage, but if breast cancer is diagnosed,
there is nowhere to go locally for support. Most of the women expressed a lack of trust in the
local medical community that stemmed from a lack of reliable medical resources.

**Priority:** Increase the number of health service providers available in Monroe County by
establishing, and funding, health system partnerships to increase access to services.

**Objectives**
- By 2017, meet with local providers to establish, and possibly fund, patient-
  navigation programs targeting Monroe County women diagnosed with breast
cancer.
- In FY16, heavily promote and host at least two grant writing workshops in
  Monroe County, to encourage more health care providers to apply for Komen
  funding.

**Service Area (Broward, Miami-Dade, Monroe)**

**Problem Statement:** In the service area as a whole, the percentage of residents living at 250
percent below the poverty line is higher than the national average, as is the unemployment rate.
The percentage of residents living with no health insurance is nearly double that of the national
average. When considering the implications of the Affordable Care Act (ACA), of particular
concern are residents who fall in the “Medicaid Gap,” undocumented women who are not
eligible for the ACA, and women who are uninsured/underinsured. A common theme among the
service area is the cost of care and lack of insurance. For those insured under the ACA, many
have been denied care because not all physicians accept the insurance. While those with no
insurance at all said the cost of services was prohibitive and often battles out with other basic
needs (food, housing, child care, etc.). Providers agreed that the service area suffers from being
underinsured and/or lacking the financial resources to follow through with care. And that while
screening services are often available to this group for free, if an uninsured/underinsured
woman is diagnosed there are very few places to go for treatment.

**Priority:** Increase free or low-cost treatment options available to uninsured/underinsured
women in the Susan G. Komen Miami/Ft. Lauderdale service area.

**Objectives**
- By 2018, a key funding priority in the Affiliate RFA will be funding free or low-
cost treatment programs in service area.
- By 2018, meet with treatment partners to try and negotiate lower costs for
  breast cancer treatment options in the Affiliate service area.


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