12. Access to Care

Having good access to healthcare means that patients can find affordable and quality care close to home. This care includes having access to primary, preventative, specialty, mental health, and dental care providers. Having private health insurance or coverage through public programs is an important factor in making healthcare affordable for most people. Prior to 2012, approximately 46 million people in the U.S. (15% of the population) did not have health insurance coverage. Of the 5 million AI/AN living in the U.S. in 2012, 23.3% did not have health coverage through private or public sources.[1] Members of federally-recognized tribes who utilize IHS, Tribal and Urban (I/T/U) clinics for primary care often have limited access to specialty, dental, and behavioral health care. This is due to chronic underfunding of the Indian health system which limits referral care, and long travel distances to reach providers of these services.

The data in this section were collected before the major provisions of the Affordable Care Act (ACA) were implemented. These data should be viewed as "baseline" information that provides a picture of disparities in healthcare coverage and access prior to ACA implementation. In 2012, 36% of AI/AN males and 48% of AI/AN females in Oregon did not have healthcare coverage. Compared to NHW in the state, fewer AI/AN reported having a primary care provider or receiving dental care in the past year. In 2013, Oregon IHS clinics had childhood immunization rates on par with the IHS national average.

The ACA will provide much needed insurance coverage to AI/AN who do not utilize the I/T/U system for primary care, and will provide additional resources to provide referral care for those who do not qualify for Purchased and Referred Care. In addition, IHS is working to increase the capacity of I/T/U clinics to provide efficient, high quality, primary care services through the Improving Patient Care collaborative. The Improving Patient Care collaborative focuses on organizing clinical care and linking patients to primary care teams. This sets the foundation for sites to become accredited as State and National Patient-Centered Medical Home programs.

1. U.S. Census Bureau. Selected population profile in the United States. American Community Survey 3-year estimates, 2010-2012.

Health Insurance Coverage

From 2006-2012, 36% of AI/AN males and 48% of AI/AN females in Oregon reported not having health insurance (Figure 12.1). Compared to their NHW counterparts, the percentage with health insurance coverage was similar for males, and was slightly lower for females (48% of AI/AN females uninsured, versus 53% of NHW females).

Table 12.1: Health insurance coverage by race, Oregon, 2011-2013.

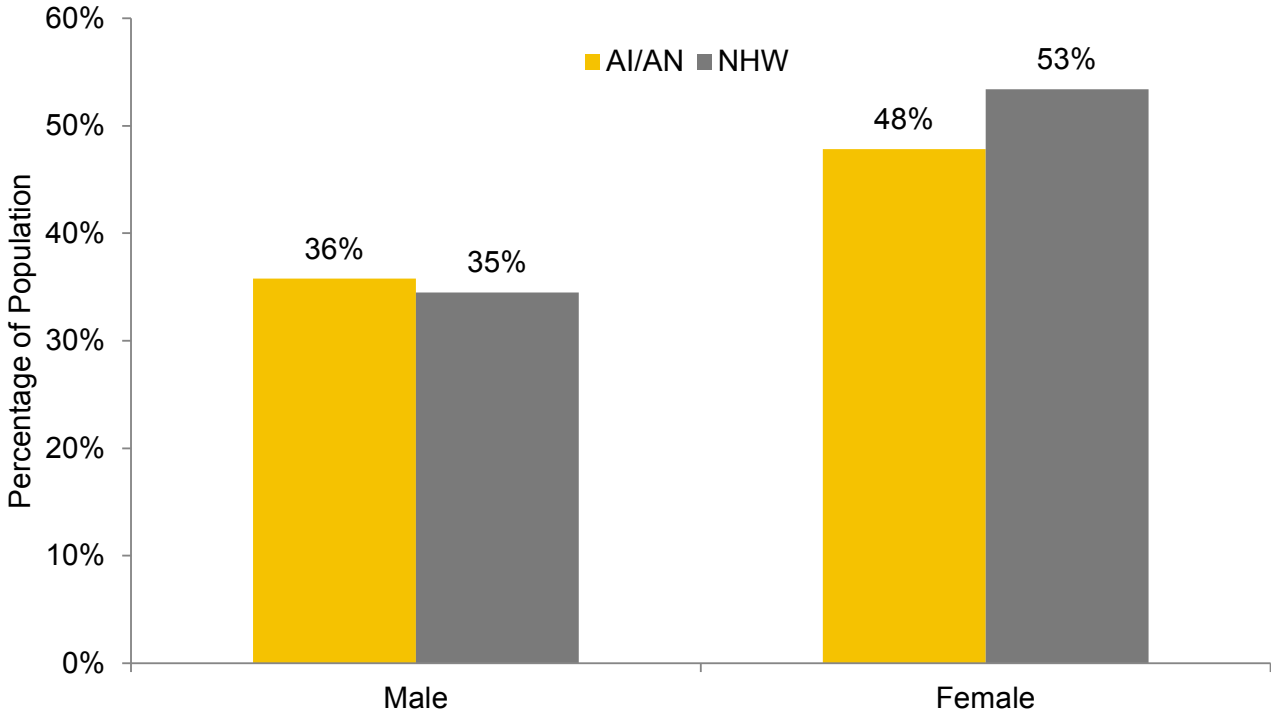
Coverage Status	AI/AN (N = 108,781) %	NHW (N = 3,002,118) %
Private Health Insurance	48.3%	70.0%
Public Coverage	39.9%	32.1%
No Health Insurance	21.3%	12.8%

N = Number (Civilian non-institutionalized population)
Note: Percentages do not add to 100% because people can have multiple sources of health insurance coverage.

Data Source: Table 12.1 – American Community Survey 3-Year Estimates, 2010-2012; Figure 12.1 – 2006 – 2012 CDC BRFSS

Data Notes: The BRFSS prevalence estimates (shown as a percentage) are weighted to make the survey responses representative of the Idaho population. The sample sizes presented below the figures are the unweighted number of people who answered this question for the indicated years.

Figure 12.1: Percentage of population without health insurance by race and sex, Oregon, 2006-2012.



Sample sizes(n): AI/AN males=170; AI/AN females=221; NHW males=13,060; NHW females=19,476.

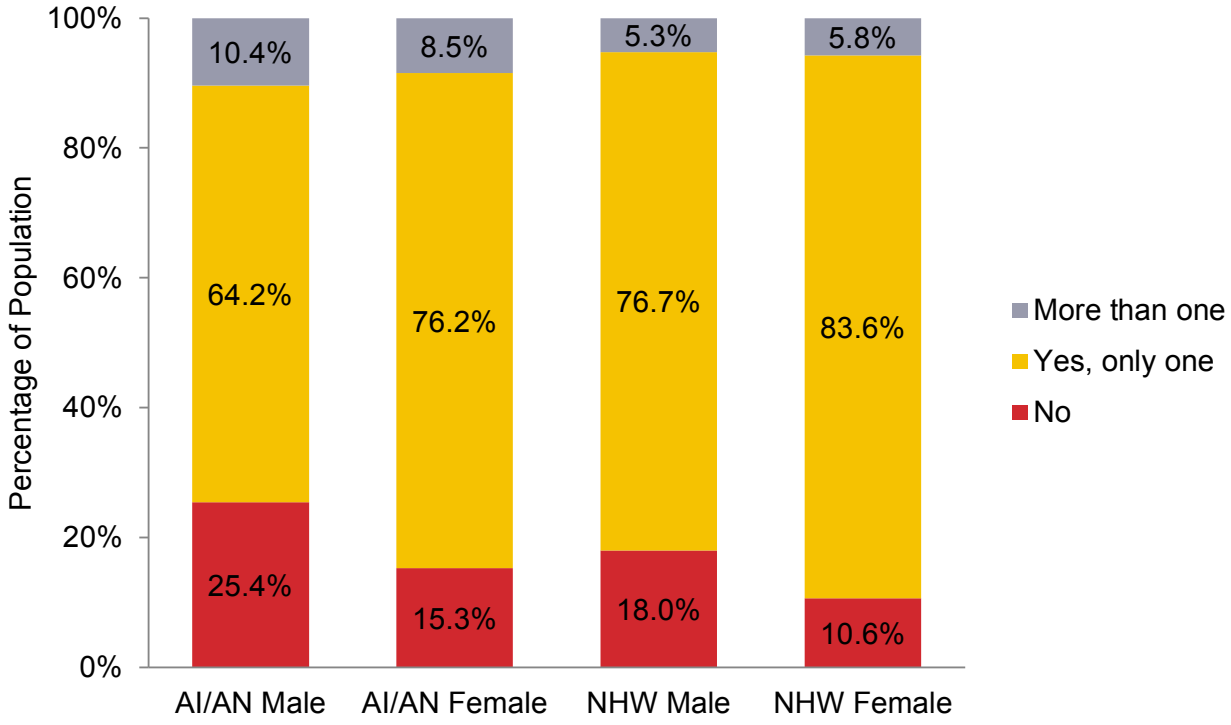
Primary Care Physician

Over 70% of AI/AN and NHW in Oregon reported having a primary care provider (Figure 12.2). However, when compared to NHW of the same sex, fewer AI/AN had a primary care provider. About 25% of AI/AN males and 18% of NHW males did not have a primary care provider. For females, 15% of AI/AN and 11% of NHW did not have a personal doctor. A small percentage of respondents reported having more than one primary care provider.

Data Source: CDC Behavioral Risk Factor Surveillance System (BRFSS), 2006-2012.

Data Notes: The BRFSS prevalence estimates (shown as a percentage) are weighted to make the survey responses representative of the Oregon population. The sample sizes presented below the figures are the unweighted number of people who answered this question for the indicated years.

Figure 12.2: Percentage of population with a primary care provider by race and sex, Oregon, 2006-2012.



Sample sizes (n): AI/AN males=413; AI/AN females=614; NHW males=30,941; NHW females=48,453.

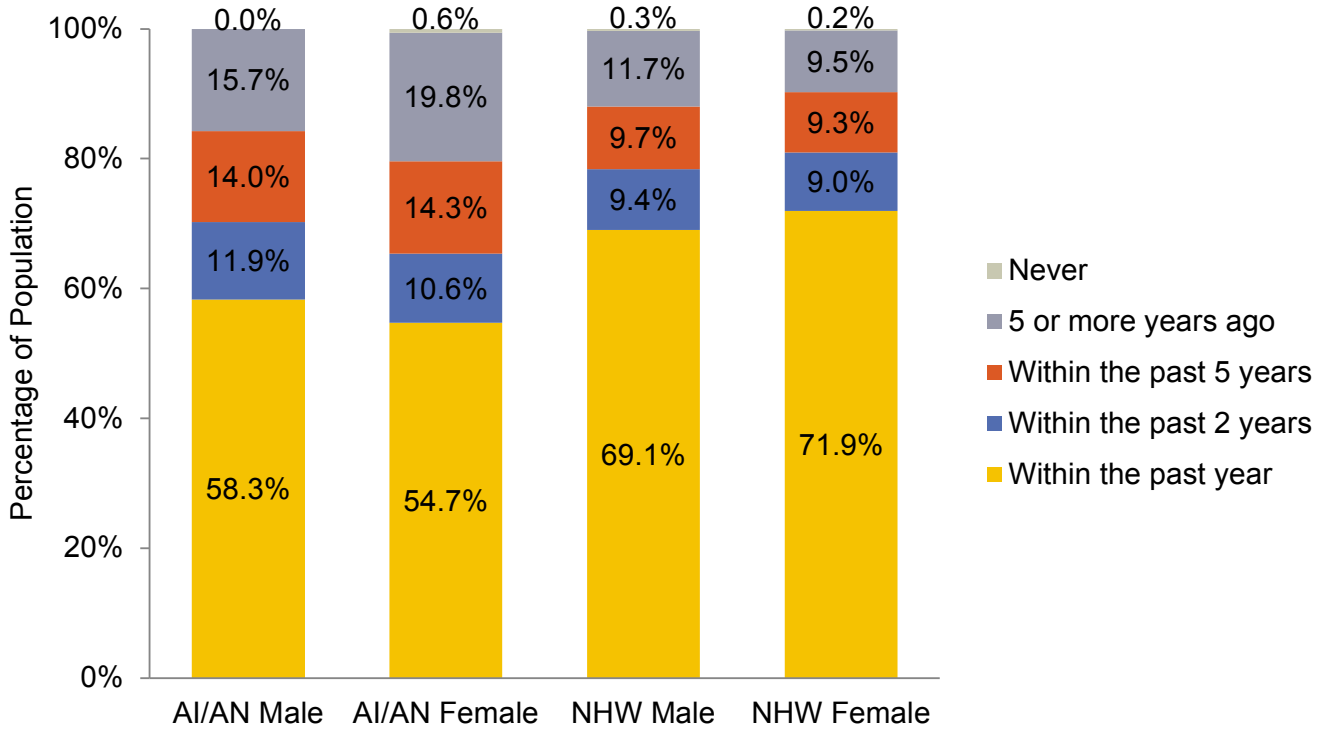
Access to Dental Care:
Time Since Last Dental Visit

From 2006-2012, fewer AI/AN in Oregon reported having a dental visit in the past year compared to NHW in the state (Figure 12.3). Among AI/AN males, 56% had a dental visit in the past year and 12% had a dental visit in the past two years; for NHW males, 68% had a visit in the past year and 9% had a visit in the past two years. Three percent of AI/AN men reported they had never had a dental visit. Among AI/AN females, 54% had a dental visit in the past year (vs. 71% of NHW females), and 11% had a dental visit in the past two years (vs. 9% of NHW females).

Data Source: CDC Behavioral Risk Factor Surveillance System (BRFSS), 2006, 2008, 2010, and 2012.

Data Notes: The BRFSS prevalence estimates (shown as a percentage) are weighted to make the survey responses representative of the Oregon population. The sample sizes presented below the figures are the unweighted number of people who answered this question for the indicated years.

Figure 12.3: Time since last dental visit by race and sex, Oregon, 2006-2012.



Sample sizes (n): AI/AN males=235; AI/AN females=329; NHW males=16,785; NHW females=26,499.

Access to Dental Care:
Visit in Past Year

Regular dental check-ups can help prevent oral infections and tooth decay, and improve overall health and well-being. The U.S. goal is for 49% of people ages 2 and older to have had a dental visit in the past year (Healthy People 2020). IHS tracks the percentage of AI/AN patients who had a dental visit in the past year. In 2013, the IHS goal for dental visits was 26.9% of all patients. About 40% of patients seen in Oregon clinics and 36% of patients in the Portland Area IHS had a dental visit in the past year, which both exceeded the 2013 goal (Figure 12.4). Compared to the national IHS average, Oregon Clinics and the Portland Area IHS had a higher percentage of patients with a dental visit in the past year.

Program Spotlight: Northwest Tribal Dental Support Center

NPAIHB's Northwest Tribal Dental Support Center (NTDSC) works with 34 IHS and tribal dental programs to improve the oral health of AI/AN in the Northwest. NTDSC has a four-pronged approach to address the needs of the dental programs in the Portland Area: 1) clinical program support, 2) prevention program support, 3) implementation of a surveillance system to track oral health status, and 4) provision of continuing dental education opportunities.

The objectives of the NTDSC are to increase overall dental access, increase access for patients with diabetes, increase use of sealants, increase use of topical fluoride treatments, and prevent and treat periodontal diseases among diabetic patients. The NTDSC communicates with local dental programs via site visits, email groups, webinars, telephone consultation, and an annual Prevention Coordinators meeting.

For more information, contact:

Ticey Casey (Siletz Tribe)

Project Manager

tcasey@npaihb.org

503-416-3267

Joe Finkbonner (Lummi Tribe)

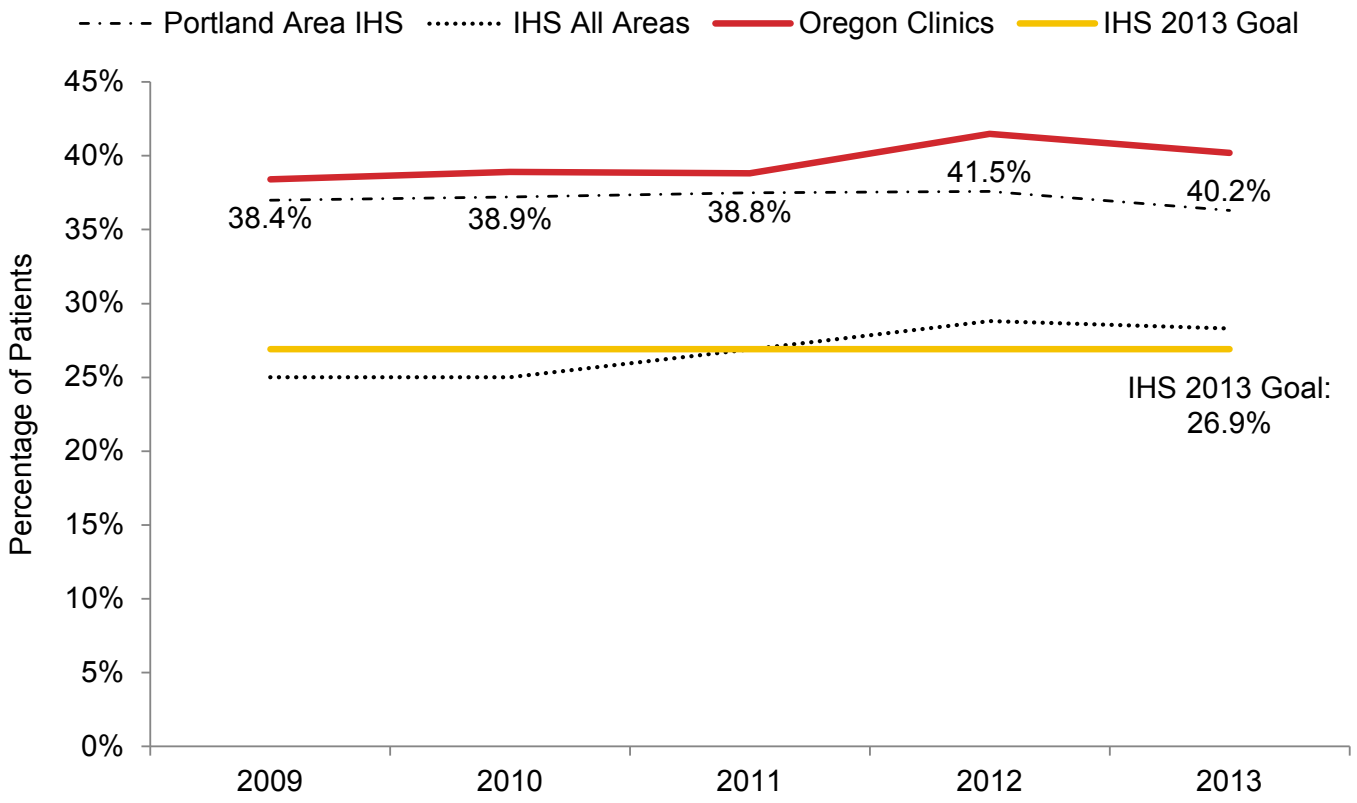
NTDSC Director

jfinkbonner@npaihb.org

503-416-3277

http://www.npaihb.org/epicenter/project/northwest_tribal_dental_support_center

Figure 12.4: Percentage of IHS AI/AN patients who had a dental visit in the past year, 2009-2013.



Data Source: Portland Area Indian Health Service.

Data Notes: Data labels only shown for Oregon clinics. Oregon clinics include non-urban federal and tribal Indian health facilities in Oregon. Portland Area IHS clinics include non-urban federal and tribal Indian health facilities in Idaho, Oregon, and Washington.

Childhood Immunizations

Vaccines help protect people from infectious diseases such as polio, measles, pertussis, and influenza. In order to be up-to-date on childhood immunizations, children between the ages of 19-35 months must receive all of the following vaccines: four doses of diphtheria, tetanus and pertussis (DTaP), three doses of polio, one dose of measles, mumps and rubella (MMR), three doses of Haemophilus influenzae B (HiB), three doses of hepatitis B, one dose of varicella, and four doses of pneumococcal. This series is abbreviated as 4:3:1:3:3:1:4.

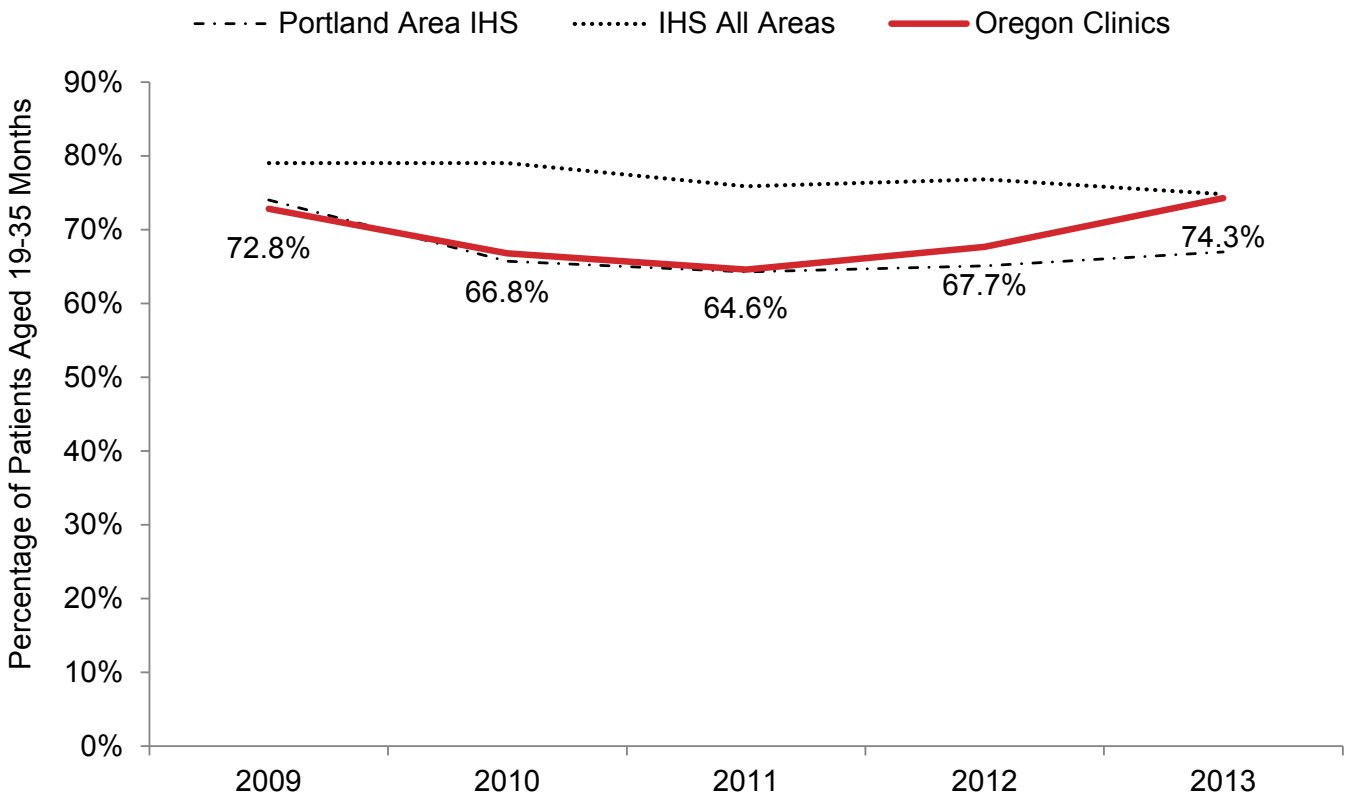
The U.S. goal is for at least 80% of children ages 19-35 months to be up-to-date on the above childhood immunizations (Healthy People 2020). IHS is using 2013 rates to establish a new baseline for this measure, and did not set a 2013 goal. The 2012 goal for this measure was 77.8%.

Childhood immunization rates for Oregon clinics and the Portland Area IHS decreased from 2009-2011 (Figure 12.5). While this trend continued for Portland Area IHS from 2011-2013, rates in Oregon clinics increased during this time period. In 2012, the childhood immunization rate for Oregon clinics (67.7%), the Portland Area IHS (65.1%), and the national IHS (76.8%) did not meet the 2012 goal of 77.8%. While Oregon clinics and the Portland Area IHS have consistently had lower childhood immunization rates than the national IHS average, in 2013 Oregon clinics were on par with the IHS national average.

Data Source: Portland Area Indian Health Service.

Data Notes: Data labels only shown for Oregon clinics. Oregon clinics include non-urban federal and tribal Indian health facilities in Oregon. Portland Area IHS clinics include non-urban federal and tribal Indian health facilities in Idaho, Oregon, and Washington.

Figure 12.5: Percentage of IHS AI/AN children (ages 19-35 months) who received the 4:3:1:3:3:1:4 immunization schedule, 2009-2013.



Adult Immunizations: Flu Vaccine

The influenza (or flu) vaccine is an effective way to prevent illnesses and deaths from the influenza virus. Flu vaccines are especially important for people who are at greatest risk of complications from the flu. These groups include people over 65 years of age, pregnant women, and people with diabetes, chronic lung disease, or other serious illnesses.

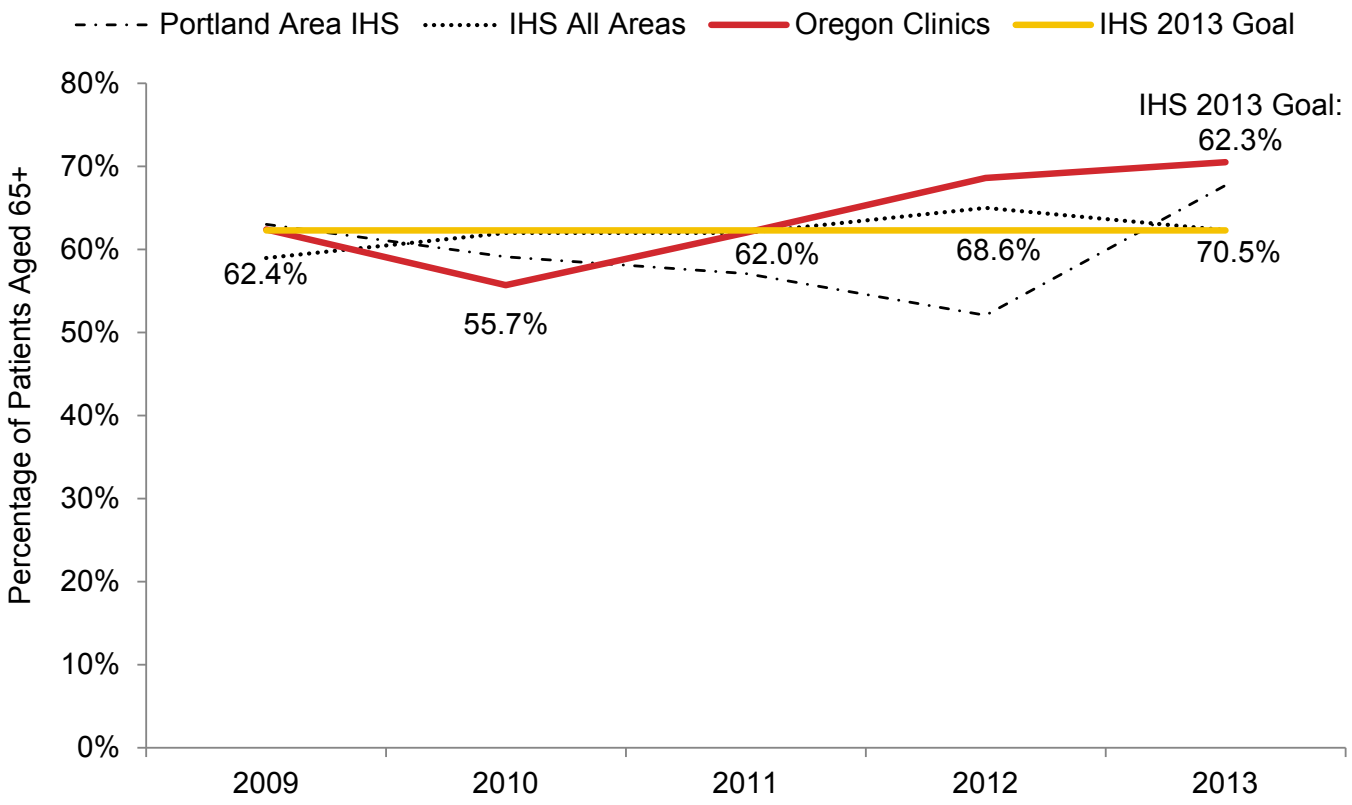
The U.S. goal is for 90% of non-institutionalized high-risk adults ages 65 and older to receive a seasonal flu vaccine each year (Healthy People 2020). IHS tracks the percentage of AI/AN patients ages 65 years and older who received the influenza vaccine in the past year. In 2013, the IHS goal for this measure was 62.3%.

The flu vaccination rate for Oregon clinics decreased from 2009 to 2010 before increasing to 70.5% in 2013 (Figure 12.6). The Portland Area IHS rate decreased from 2009 to 2012, but increased from 52.1% in 2012 to 67.7% in 2013. The national IHS average steadily increased from 2009 to 2012, and dropped slightly in 2013. All three areas met the 2013 goal for this measure.

Data Source: Portland Area Indian Health Service.

Data Notes: Data labels only shown for Oregon clinics. Oregon clinics include non-urban federal and tribal Indian health facilities in Oregon. Portland Area IHS clinics include non-urban federal and tribal Indian health facilities in Idaho, Oregon, and Washington.

Figure 12.6: Percentage of IHS AI/AN patients ages 65 years and older who received a flu vaccine in the past year, 2009-2013.



Adult Immunizations: Pneumococcal Vaccine

The pneumococcal vaccine can prevent illnesses such as pneumonia, meningitis, and bacteremia. This vaccine is especially important for people who may have weak immune systems, including people over the age of 65, those with diabetes or other serious illnesses and those who smoke tobacco.

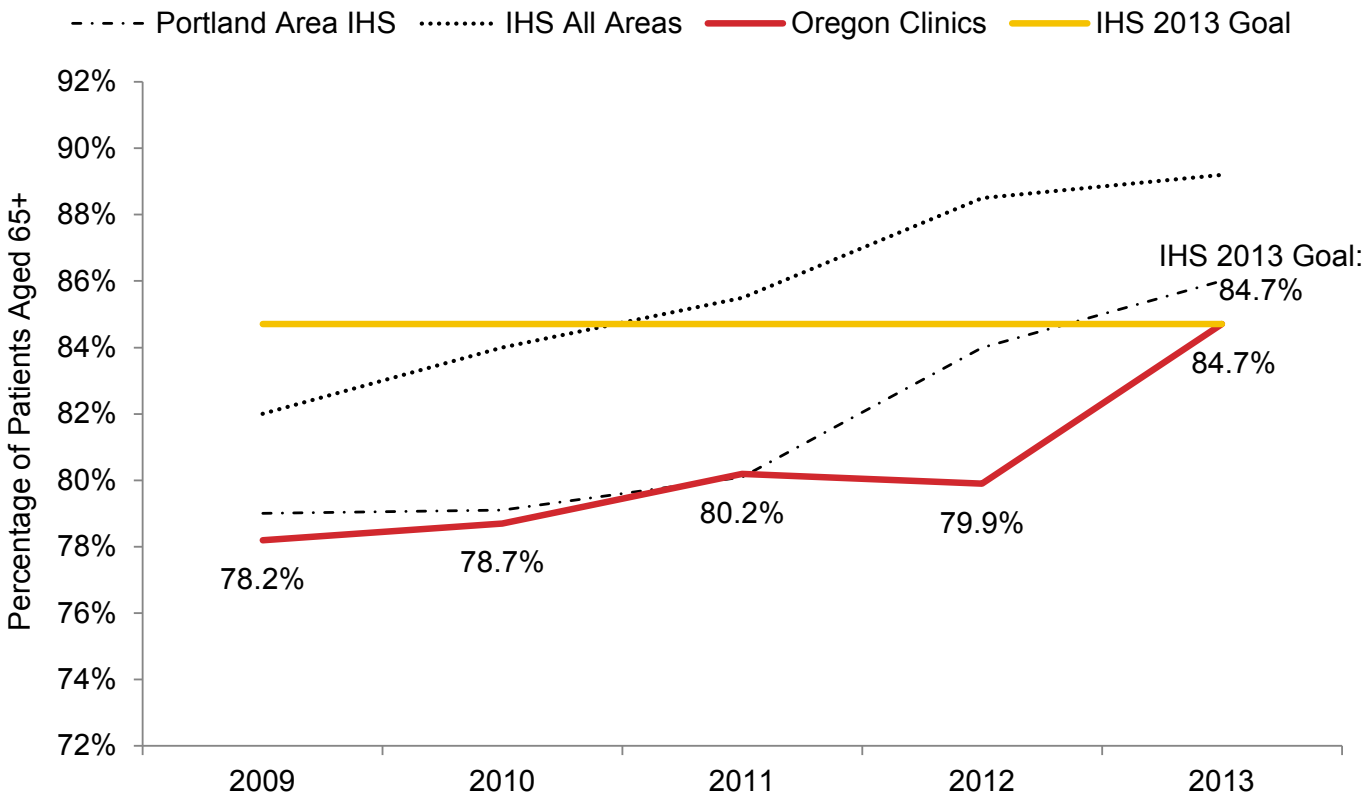
The U.S. goal is for 90% of adults ages 65 and older to receive a pneumococcal vaccination (Healthy People 2020). IHS tracks the percentage of AI/AN patients ages 65 years and older who received a pneumococcal vaccination once after age 65. The IHS 2013 goal for this measure was 84.7%.

Oregon clinics, the Portland Area IHS, and the national IHS all met or exceeded the 2013 goal for pneumococcal vaccinations (Figure 12.7). Pneumococcal vaccination rates across all three areas have steadily increased since 2009.

Data Source: Portland Area Indian Health Service.

Data Notes: Data labels only shown for Oregon clinics. Oregon clinics include non-urban federal and tribal Indian health facilities in Oregon. Portland Area IHS clinics include non-urban federal and tribal Indian health facilities in Idaho, Oregon, and Washington.

Figure 12.7: Percentage of IHS AI/AN patients ages 65 years and older who ever received a pneumococcal vaccine, 2009-2013.



Program Spotlight: Northwest Tribal Immunization Project

Immunizations are a safe and effective means for preventing disease in children, adolescents, and adults. Although many vaccine-preventable childhood diseases are near record low levels, recent outbreaks of diseases such as pertussis and measles serve as a reminder that these diseases have not disappeared. Since 2008, NPAIHB's Immunization Program has focused on understanding and addressing the causes of low immunization coverage among AI/AN in the Pacific Northwest, especially among infants and young children. The program supports IHS and tribal clinics in reporting immunization coverage data for children, adolescents and adults on a quarterly basis. Additional reports are collected annually to monitor influenza vaccination rates for both patients and healthcare providers. These data have been useful in addressing recent epidemics of vaccine preventable diseases such as the influenza A H1N1 pandemic and the 2012 pertussis epidemic in Washington and parts of Idaho and Oregon.

The Immunization Program supports immunization coordinators from 33 clinical sites by sponsoring annual RPMS trainings and holding monthly calls. Program staff also serve as liaisons between clinical sites and State health departments, the IHS National Immunization Program and CDC, and assist sites with locating vaccine supplies, responding to vaccine recalls, and undertaking special projects to improve immunization coverage and immunization data exchange with State Immunization Information Systems. The program is funded by the Portland Area Indian Health Service.

For more information, contact:

Clarice Charging (Mandan/Hidatsa)
Immunizations Coordinator
ccharging@npaihb.org
503-416-3256

Thomas Weiser, MD, MPH
Medical Epidemiologist
tweiser@npaihb.org
503-416-3298

http://www.npaihb.org/epicenter/project/northwest_tribal_immunization_project