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 4.6 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 Idaho, 27% of AI/AN reported being without any health care coverage. These data are from self-identified AI/AN so this may include some people who are not eligible for IHS services. About the same number reported having no primary care physician. About a third had seen a dentist in the past year. Two thirds of AI/AN children were up to date on their vaccines, which was similar to the rest of the Portland Area; however, this number has been falling in recent years. More than half of adults had received a flu vaccine and almost 90% had received a pnuemococcal vaccine.

The ACA will provide much needed insurance coverage to AI/AN who do not utilize the I/T/U system for primary care. It will also provide additional resources to provide referral care for those who do not qualify for Purchased and Referred Care (PRC, formerly known as Contract Health Services [CHS]). 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

Prior to 2013, the majority of AI/AN and NHW in Idaho reported having some kind of health coverage through private health insurance or public coverage (Table 12.1). However, a higher percentage (27%) of AI/AN did not have healthcare coverage compared to NHW in the state (14%). For NHW, females were more likely to lack health insurance than males (Figure 12.1); however, the proportion of uninsured was about the same for male and female AI/AN.

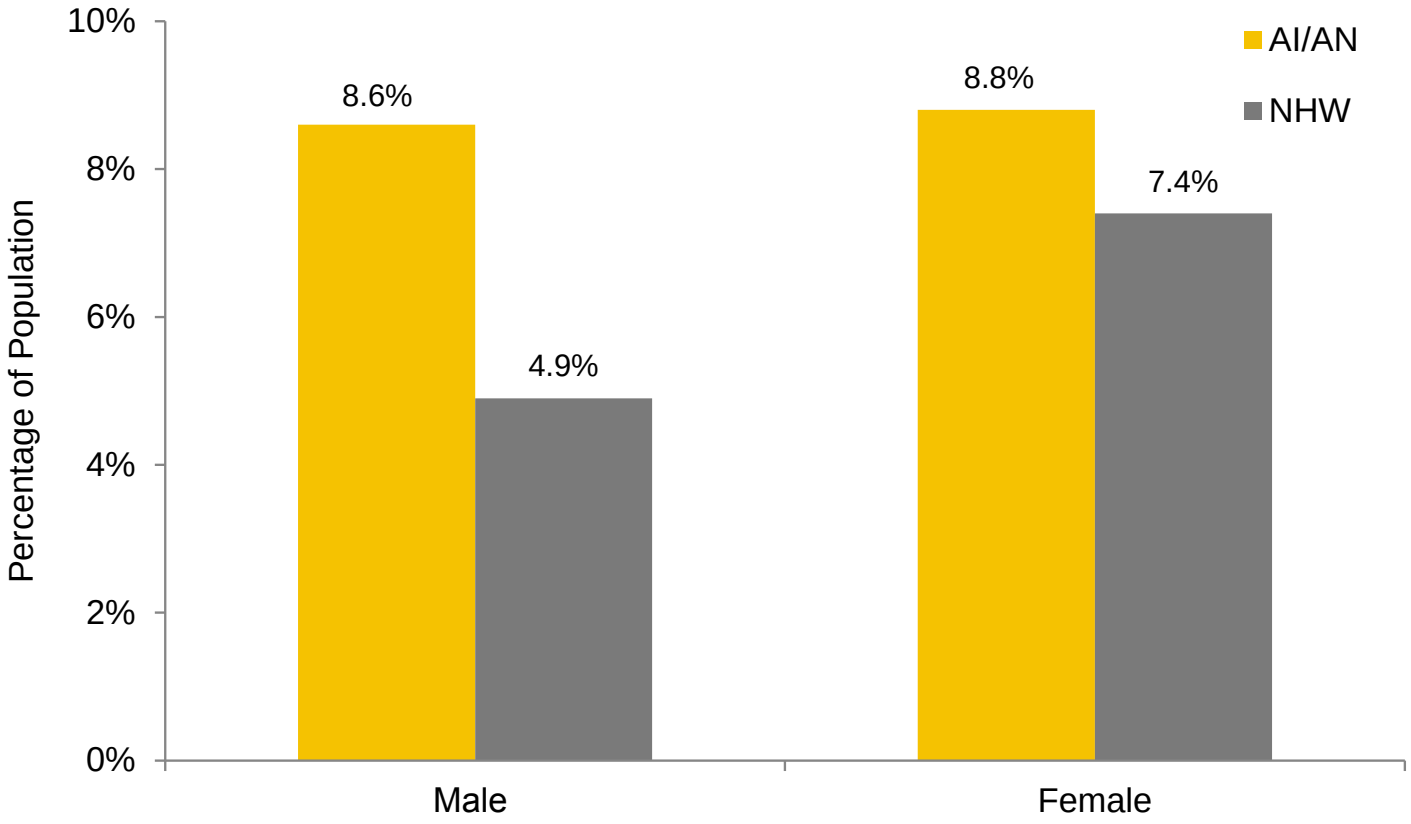
Table 12.1: Health insurance coverage by race, Idaho, 2010-2012.

Coverage Status	AI/AN (N = 35,978)	NHW (N = 1,310,281)
Private Health Insurance	46.8%	71.0%
Public Coverage	36.8%	27.9%
No Health Insurance	27.1%	14.4%

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, Idaho, 2006-2012.



Sample sizes(n): AI/AN males=185; AI/AN females=313; NHW males=13,758; NHW females=20,918.

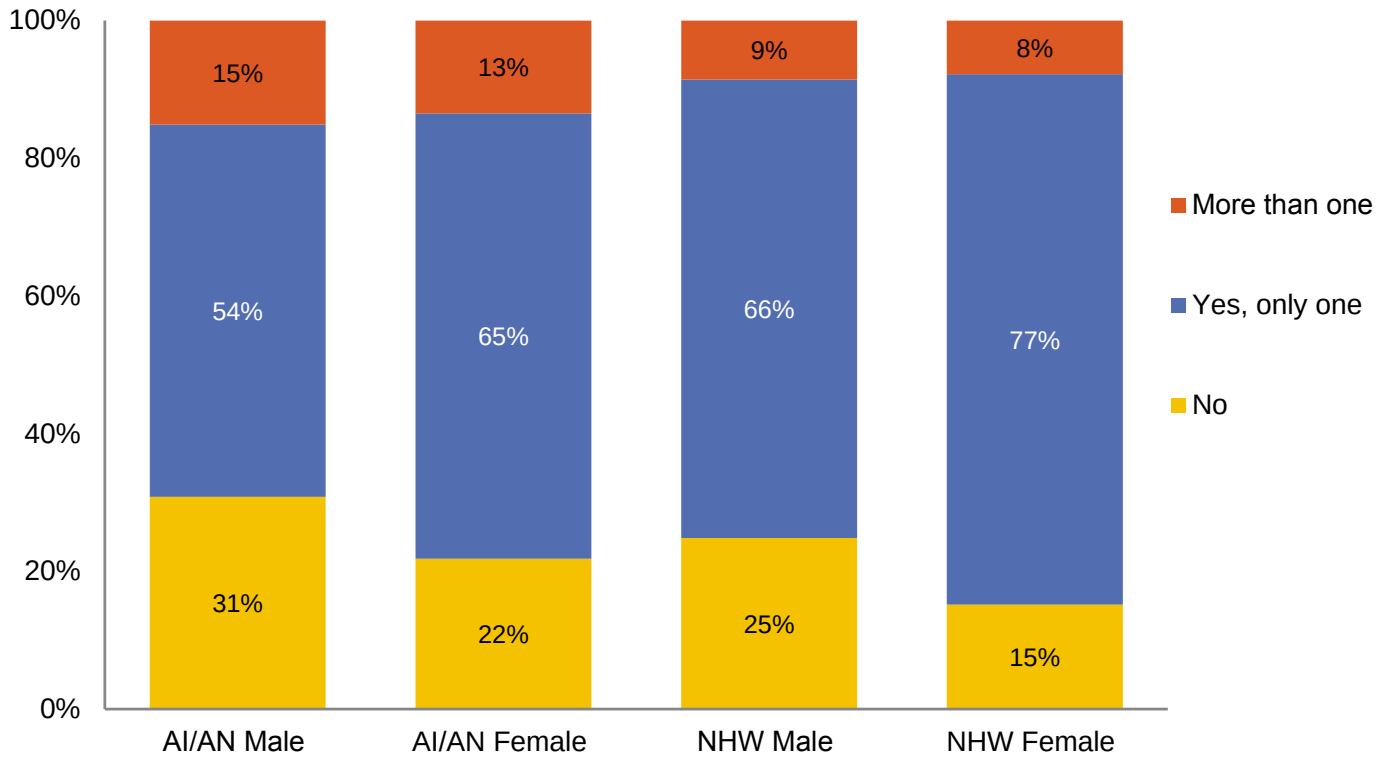
Primary Care Physician

The majority of AI/AN and NHW in Idaho 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 1 in 3 AI/AN males and 1 in 4 NHW males did not have a primary care provider. For females, one quarter of AI/AN and 15% of NHW were without a primary care provider. AI/AN were slightly more likely to have more than one primary care doctor than NHW.

Data Source: 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 12.2: Percentage of population with a primary care provider by race and sex, Idaho, 2006-2012.



Sample sizes (n): AI/AN males=530; AI/AN females=875; NHW males=36,557; NHW females=56,587.

Access to Dental Care

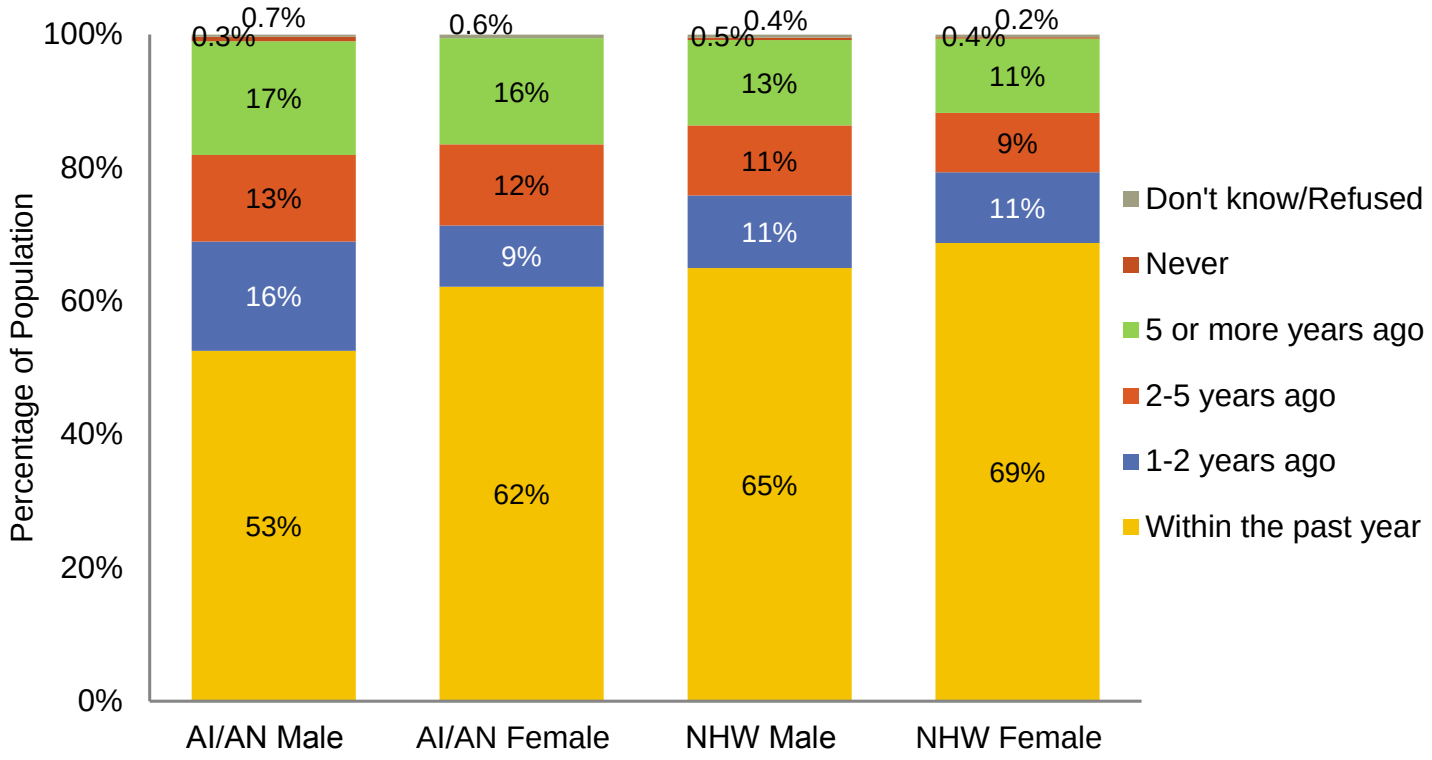
Time Since Last Dental Visit

From 2006-2012, fewer AI/AN in Idaho reported having a dental visit in the past year compared to NHW in the state (Figure 12.3). Among AI/AN males, 53% had a dental visit in the past year and 69% had a dental visit in the past two years; for NHW males, 65% had a visit in the past year and 77% had a visit in the past two years. Less than one percent of AI/AN men had never had a dental visit. Among AI/AN females, 62% had a dental visit in the past year (vs. 69% of NHW females), and 71% had a dental visit in the past two years (vs. 80% of NHW females).

Data Source: 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 12.3: Time since last dental visit by race and sex, Idaho, 2006-2012.



Sample sizes (n): AI/AN males=293; AI/AN females=534; NHW males=221,418; NHW females=33,513.

Dental 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 31% of patients seen in Idaho clinics had a dental visit in the past year, which exceeded the 2013 goal and the IHS national average (Figure 12.4), but was lower than the Portland Area IHS average.

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.

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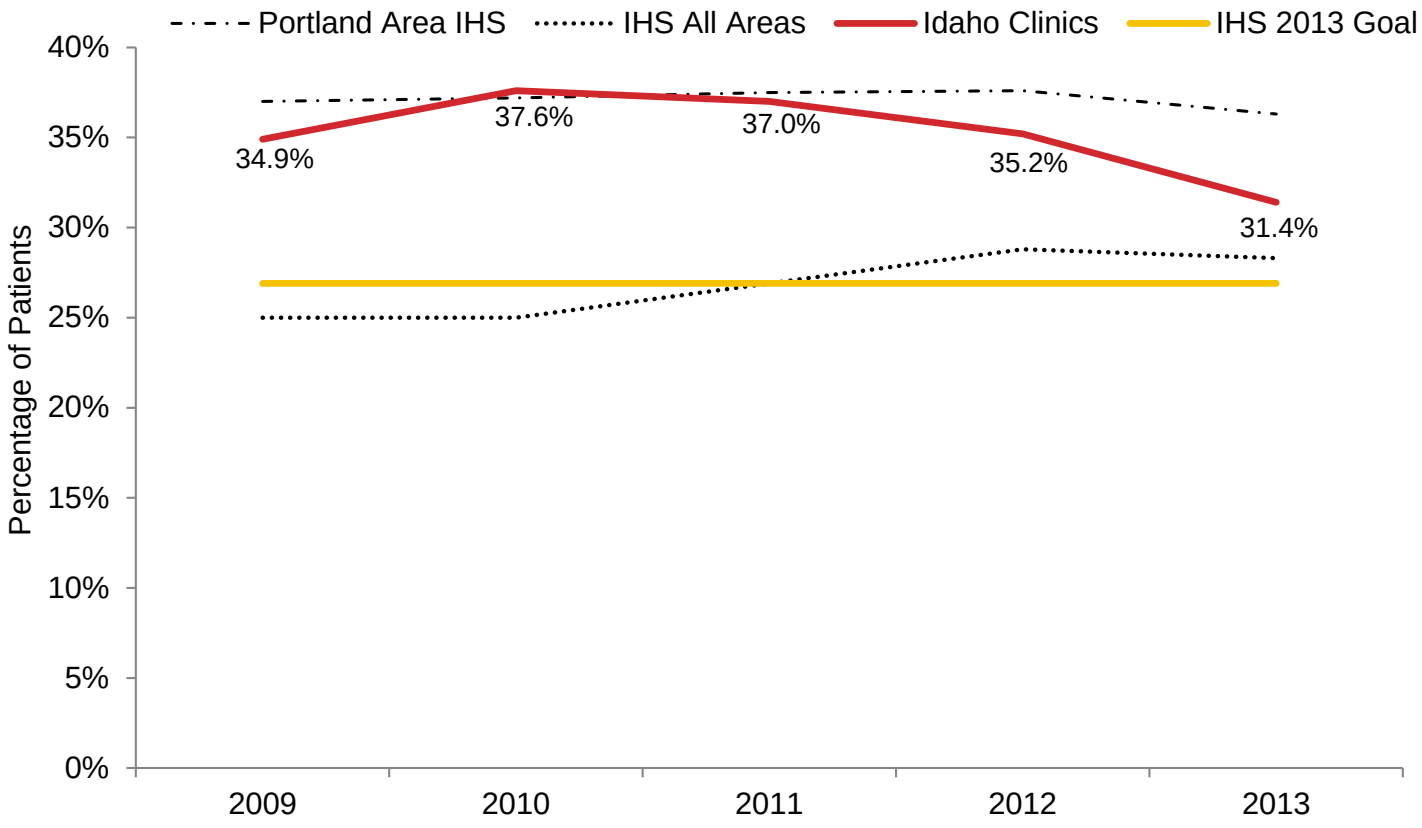
Figure 12.4: Percentage of IHS AI/AN patients who had a dental visit in the past year, 2009-2013.



Data Source: Portland Area Indian Health Service.

Data Notes: Data labels only shown for Idaho clinics.

Idaho clinics include non-urban federal and tribal Indian health facilities in Idaho. Portland Area IHS clinics include non-urban federal and tribal Indian health facilities in Idaho, Oregon, and Washington.

Immunizations

Childhood

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%.

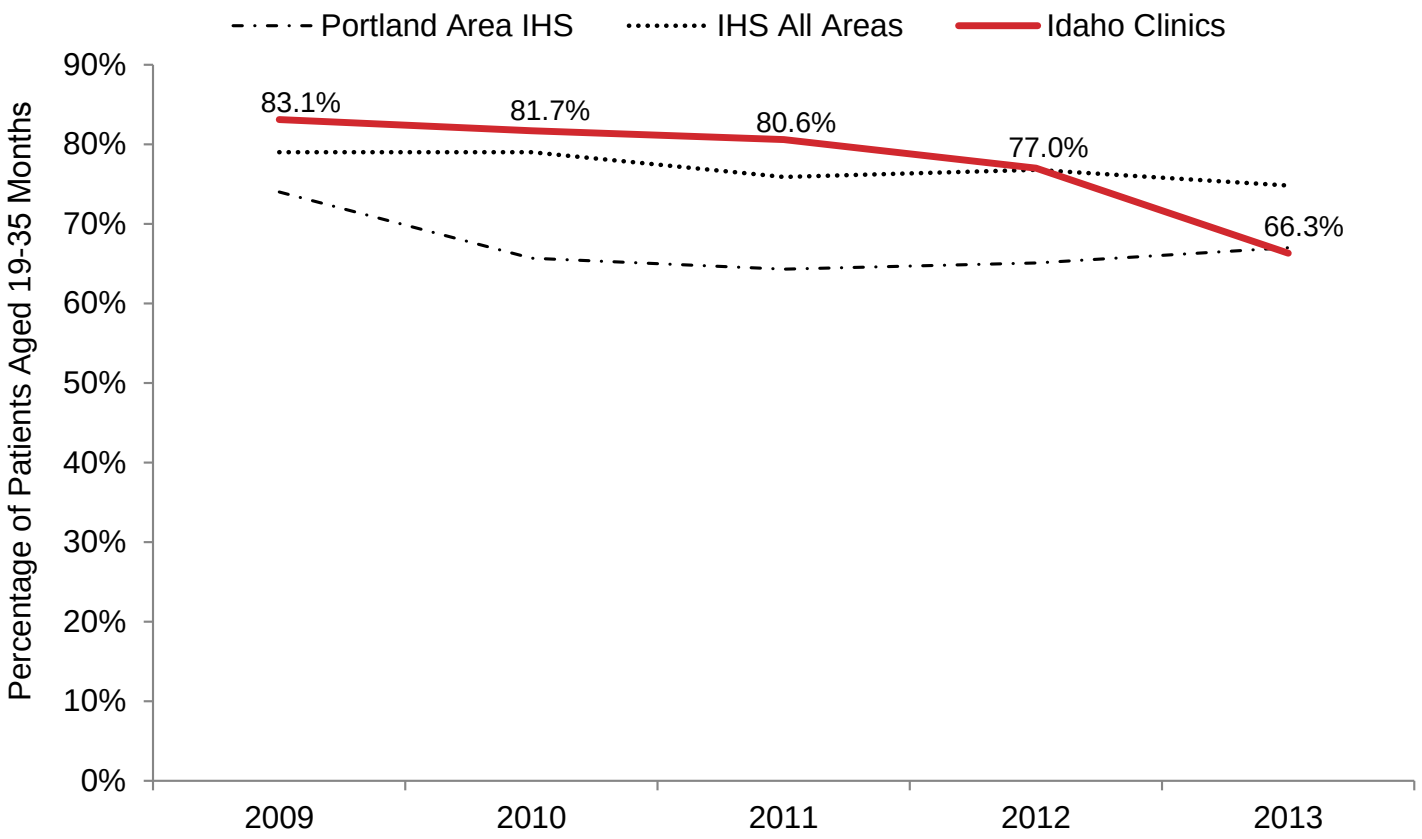
Childhood immunization rates for Idaho clinics and the Portland Area IHS have decreased since 2009 (Figure 12.5). In 2012, the childhood immunization rate for Idaho clinics (66.3%), the Portland Area IHS (65.1%), and the national IHS (76.8%) did not meet the 2012 goal of 77.8%. Idaho clinics have had consistently higher immunization rates than the Portland Area IHS averages, with the exception of 2013 when Idaho clinics were just about the same as the area average. From 2009 to 2012, Idaho clinics were exceeding or the same as the IHS national average for childhood immunizations; however, in 2013 they fell below the national rates.

Data Source: Portland Area Indian Health Service.

Data Notes: Data labels only shown for Idaho clinics.

Idaho clinics include non-urban federal and tribal Indian health facilities in Idaho. 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 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%.

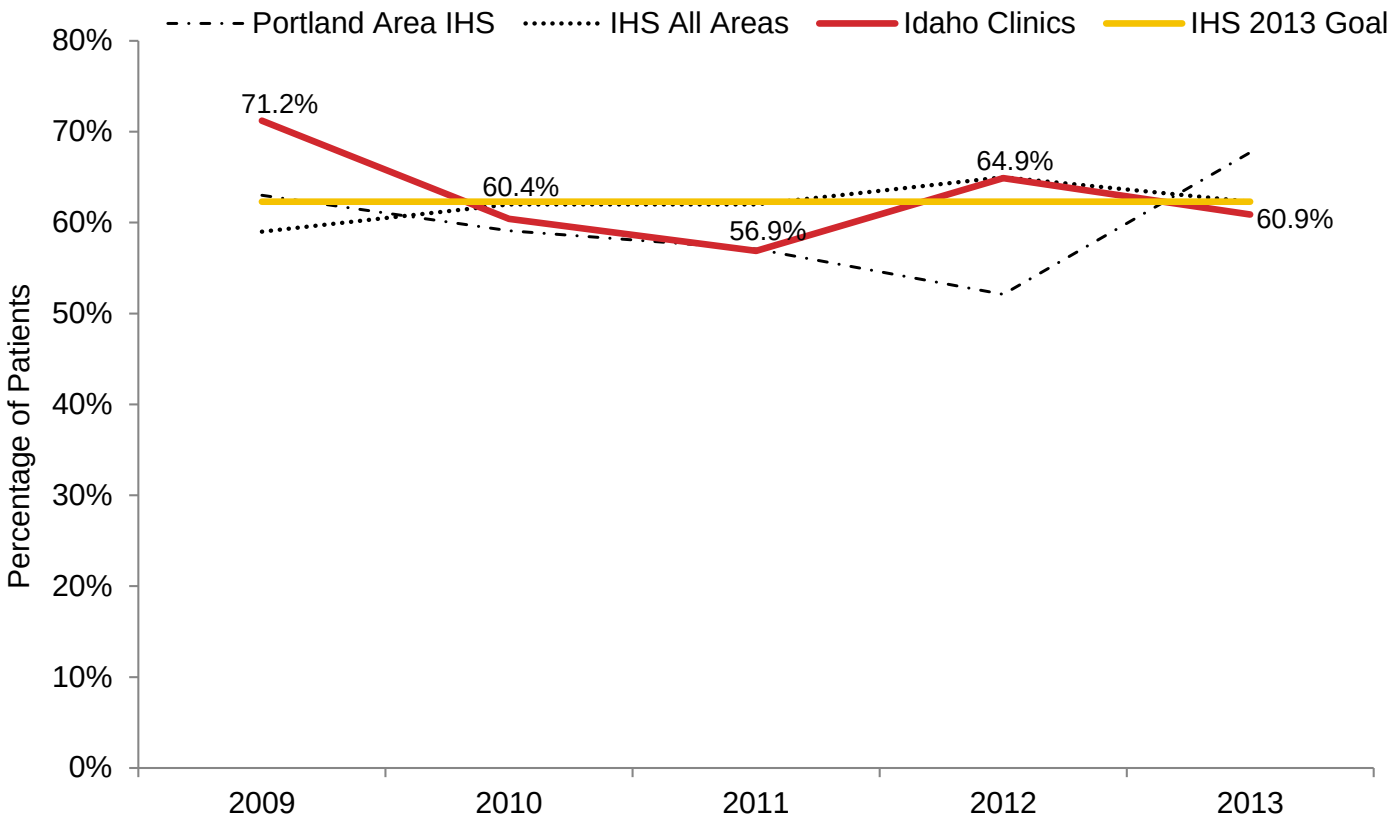
The flu vaccination rate for Idaho clinics decreased from 2009 to 2011 before increasing to 60.9% in 2013 (Figure 12.6). The Portland Area IHS rate decreased from 2009 to 2012, but increased from 52.1% in 2012 to 67.7% in 2013. The national IHS average steadily increased from 2009 to 2012, and dropped slightly in 2013. In 2013 Idaho clinics fell slightly below the IHS goal of 62.3%.

Data Source: Portland Area Indian Health Service.

Data Notes: Data labels only shown for Idaho clinics.

Idaho clinics include non-urban federal and tribal Indian health facilities in Idaho. 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 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%.

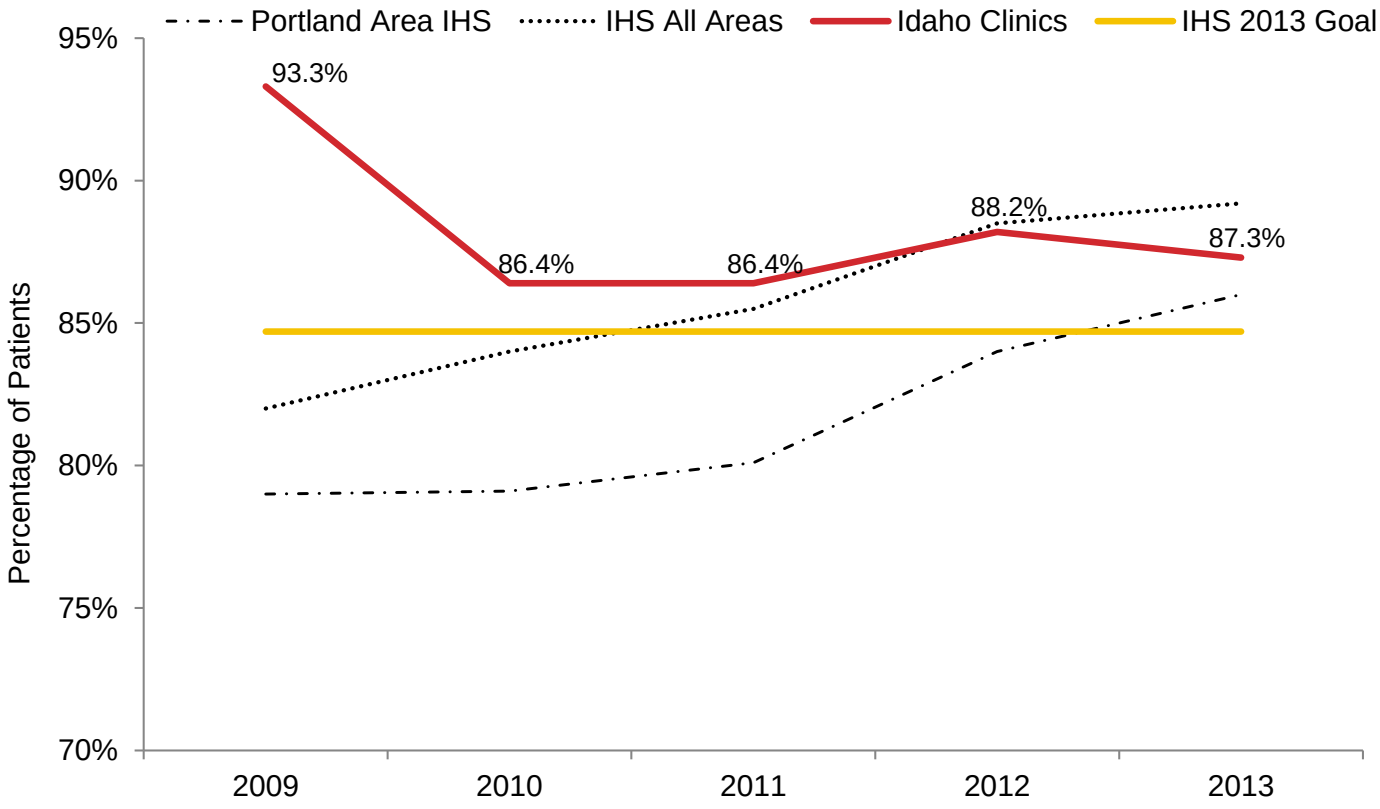
Idaho clinics, the Portland Area IHS, and the national IHS all exceeded the 2013 goal for pneumococcal vaccinations (Figure 12.7). In 2013, the vaccination rate for Idaho clinics was 87.3%, while the Portland Area IHS was 86%, and the national average was 89.2%. Pneumococcal vaccination rates have steadily increased since 2009 for the Portland Area and IHS nationally; for Idaho clinics the rates dropped between 2009 and 2010, but have been stable since then.

Data Source: Portland Area Indian Health Service.

Data Notes: Data labels only shown for Idaho clinics.

Idaho clinics include non-urban federal and tribal Indian health facilities in Idaho. 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 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:

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