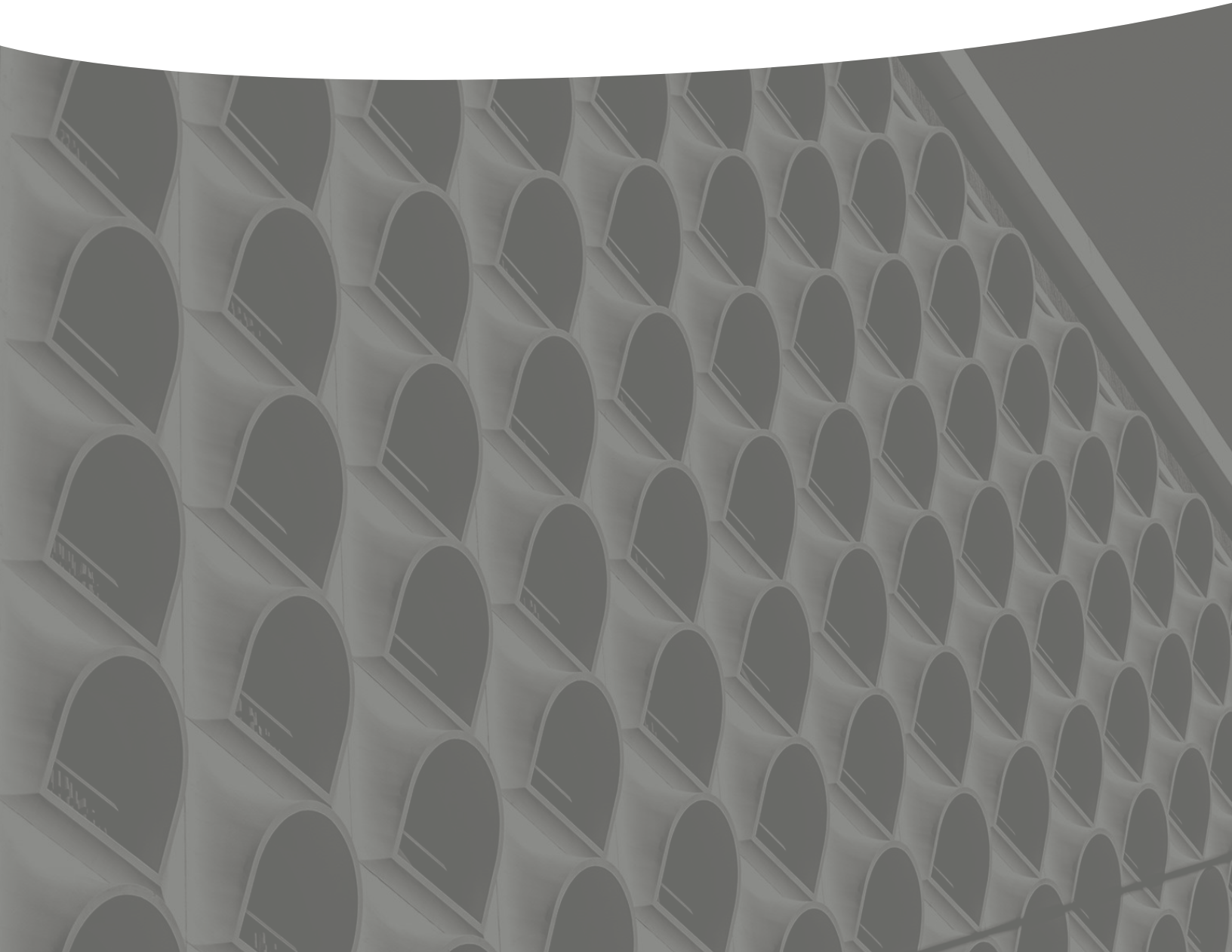
Community Health Profile

Individual Site Report | Portland UIHP Service Area

August 2017

Urban Indian Health Institute
A Division of the Seattle Indian Health Board



The mission of the UIHI is to support the health and well-being of urban Indian communities through information, scientific inquiry, and technology.

This report was prepared by: Adrian Dominguez, MS; Joshua Smith, BS; Kelsey Liu, MPH; with the support of Alyssa Yang, MPH; Brinda Sivaramkrishinan, MPH; Colin Gerber, MPH; and Leah Dodge, MPH.

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Acknowledgements

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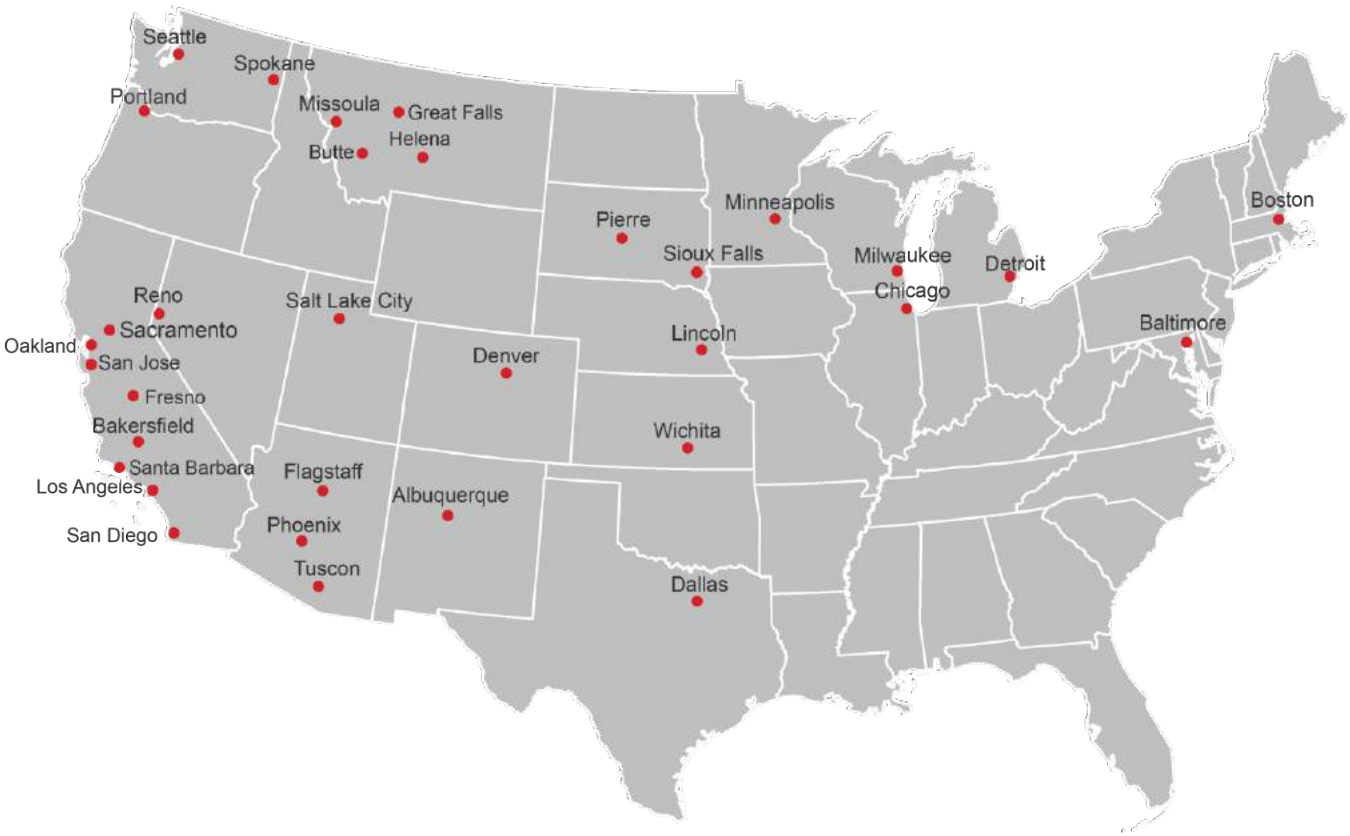
The Urban Indian Health Institute would like to thank the staff at the Urban Indian Health Programs, social service and faith based agencies for the excellent work they do daily on behalf of their communities.

URBAN INDIAN HEALTH PROGRAMS

Urban Indian Health Programs (UIHPs) are private, non-profit corporations that serve American Indian and Alaska Native (AI/AN) people in select cities with a range of health and social services from outreach and referral to full ambulatory care.

UIHPs are a network of 32 independent health agencies funded in part under Subchapter IV (formerly Title V) of the Indian Health Care Improvement Act and receive limited grants and contracts from the federal Indian Health Service (IHS). UIHPs are located in 18 states and serve individuals in approximately 100 U.S. counties where over 1.2 million AI/ANs reside.[1] In addition, there are numerous social service and faith based organizations serving the public health needs of urban AI/ANs.

UIHPs provide traditional health care services, cultural activities, and a culturally appropriate place for urban AI/ANs to receive health care. Comprehensive clinics provide direct primary care for at least 40 hours per week, Limited clinics provide direct primary care services for under 40 hours per week, and Outreach and Referral sites do not provide direct care services on site but refer patients to external health care providers. The map below identifies these sites, some of whom have multiple clinic locations. It does not include AI/AN social service or faith based agencies.



For more information on individual Urban Indian Health Programs, visit http://www.uihi.org/urban-indian-health-organization-profiles/.

INTRODUCTION AND PURPOSE

Introduction

This community health profile provides an overview of the health status of AI/ANs living in select urban counties served by the Native American Rehabilitation Association (NARA), which is one of 32 Subchapter IV UIHPs across the country. The counties analyzed in this report are defined as Clackamas County, Multnomah County, Washington County and Clark County by IHS. This report will refer to the service area the Portland service area and Native American Rehabilitation Association interchangeably. This document presents data specific to demographics, social determinants of health, mortality, and maternal and child health. The data used is from national data sources and in no way uses patient data from NARA. The profile examines and addresses the disparities that exist among the urban AI/AN population compared to the non-Hispanic White (NHW) population and demonstrates the disproportionality in outcomes and risk factors that adversely affect them. Data for this profile comes from the U.S. Census, the American Community Survey, and the U.S. Center for Health Statistics.

Not all issues important to the health of urban AI/AN communities are included in this report. Locally collected data may provide additional information about the health of AI/ANs living in the Portland service area. Data presented in this report may be most useful when combined with aggregate data, stories about patients and community members, and local surveillance or survey data when available.

Purpose

Improving community health through effective planning and decision-making requires good information about the factors that influence the health status of community members.[2] The following examples suggest possible ways to use the data from this report. UIHI is available to provide technical assistance on how to use the following data.

Program Planning

Data in this report can be used by UIHPs to identify health priorities, allocate resources, and guide the development of new programs.

Grant Writing

Data and figures in this report may be useful to include as background information for grant applications. This information can illustrate existing health disparities in the AI/AN population compared to NHW. This report can also be cited as the reference.

Identifying Gaps in Data

This report may also reveal current gaps in nationally collected data. For example, notably low mortality rates may indicate the need for improvements to race determination in death records. State and regional linkage projects can help correctly classify AI/ANs in state death records.[3] Oversampling AI/ANs in national surveys is another way to improve data collection by providing sufficient statistical power to provide more stable estimates.

METHODOLOGY

Methods

Analysis

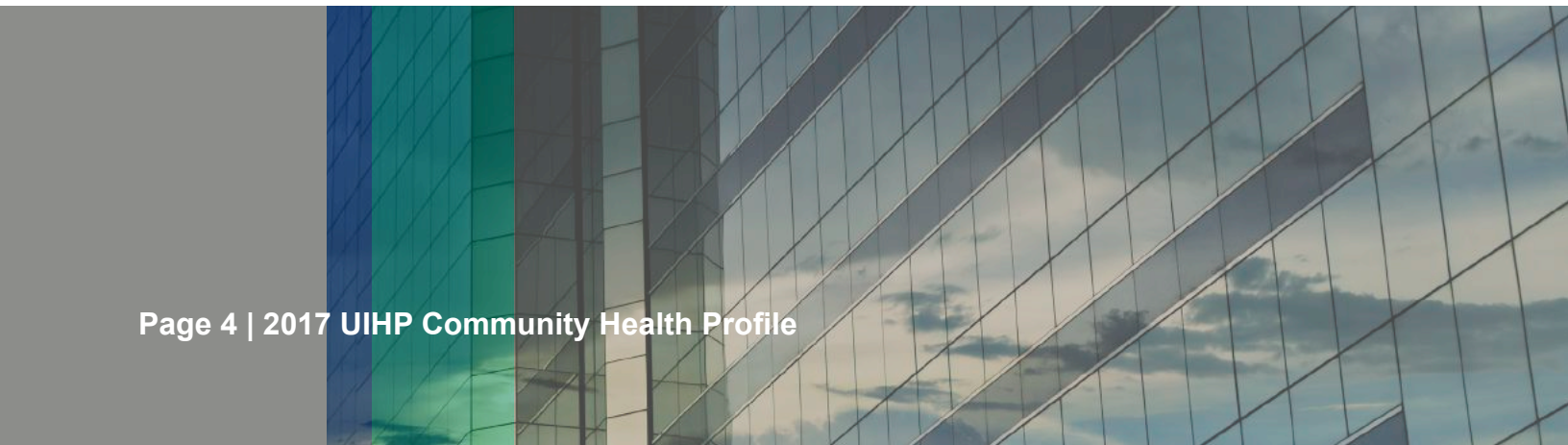
The data for this report only includes information from Clackamas County, Multnomah County, Washington County and Clark County residents. For each indicator, prevalence or incidence was calculated for the AI/AN population and compared with the NHW population. Because NHWs are the racial/ethnic majority, this population was chosen as the comparison group. The AI/AN population was defined as AI/AN only (not in combination with other races) unless otherwise indicated. The NHW population was defined as White only and excluded the Hispanic population unless otherwise indicated. Results were calculated using aggregate data from a two- to five-year time-period in order to have sufficient data to provide stable estimates and protect individual privacy. The mortality data presented is only representative of Clackamas and Clark County due to the lack of data from all other counties in the service area.

In some instances, confidence intervals were calculated and used to show differences in outcomes for specific indicators displayed in bar graphs. Confidence intervals are ranges of numbers used to assess the accuracy of a point estimate and measure the variability in the data. The point estimate may be a rate, such as a death rate or an infectious disease rate, or a frequency, such as the percent of individuals living in poverty or the percent of adults experiencing unemployment. Confidence intervals account for the uncertainty that arises from the natural variation inherent in the world around us. Confidence intervals also account for the difference between a sample from a population and the population itself. For analyses included in this report, confidence intervals were calculated at a p-value of <0.05, the 95 percent confidence level. This means that 95 times out of 100 the confidence interval captures the true value for the population. Differences in outcomes were called statistically significant if confidence intervals of the study group (AI/AN), did not overlap with the comparison group (NHW). Data analysis for indicators were analyzed using the statistical software StataSE version 13 or SAS version 9.4.

Indicator Selection

A list of indicators for the community health profile were selected after an analysis of the available data sources. Sample size and stratification of each population based on demographics, such as age groups, gender, and education, were considered and used if the sample size was sufficient.

This profile uses national surveillance data. This report does not pull data from the client database of the NARA or any other urban AI/AN serving organization in the area. There may be information not captured by these systems that better represent the unique strengths and challenges in communities served by NARA. Local sources of data may provide a more region-specific and comprehensive understanding of the community's health.



METHODOLOGY

Data Limitations

The contents of this report are specific to national surveillance data for Clackamas County, Multnomah County, Washington County and Clark County residents only.

Although data analysis and assessment of results were conducted for 42 indicators, data limitations were observed and experienced during the selection of these indicators and their analyses for this report. In some instances, the number of cases/sample size was limited, thus impacting the analysis and preventing or limiting the reporting of results. For example, the mortality section of this report only showcases information from Clackamas County and Clark County because the other counties had sample sizes that were too small to analyze accurately. Frequently, data was only available for AI/ANs alone and was not inclusive of AI/ANs who also identify with another race or ethnicity. Thus, the estimates provided in this report may be an underestimation of the true value of the outcome or risk factor for any indicator analyzed in this report.

Another factor affecting and limiting the analysis of data are errors in racial misclassification, particularly for demographic and mortality data. Racial misclassification is defined as incorrect coding of an individual's race or ethnicity in public records.[4] This can greatly underestimate the true rate of disease, risk factor, or outcome. AI/ANs are especially likely to experience problems of incorrect classification on death certificates; therefore, true mortality rates among AI/ANs are assumed to be higher than reported numbers suggest. Because mortality data are extracted from death certificates, the race/ethnicity category is not self-reported and is often completed by a funeral director based on information received from a family member or personal observation. In a national sample, age-adjusted mortality for AI/ANs was underestimated by 9.7%.[5] The bias created by misclassification varies by age, proximity to a reservation, and cause-of-death.[6] Based on documented racial misclassification of AI/ANs in surveillance data, any of the health disparities presented in this community health profile are assumed to be larger than reported.

Lastly, we would like to acknowledge the presence of other gender identities outside of male and female categories including Two-Spirit and transgender identities which are systemically ignored and not included in these larger national surveillance systems.[7] The lack of these other categories for gender can lead to invisibility and lack of information to support the health and well-being of people outside of binary gender identities, thus limiting our data analysis.

DATA SOURCES

Data Sources

2010 U.S. Census

The U.S. Census takes place every 10 years and provides official population counts for individuals living in the United States and provides information by age, race, Hispanic origin, and sex. In 2010, the U.S. Census allowed individuals to self-report belonging to more than one race group. When determining a population count, this report considers people to be of AI/AN race if they report AI/AN as their only race or if they report being AI/AN in combination with other races. Some Census statistics are not easily accessible when including individuals who report multiple races. For these indicators in the profile, only individuals who report AI/AN alone are included.

For more information about the U.S. census, visit: www.census.gov.

American Community Survey

The American Community Survey (ACS) is a nationwide, continuous survey that collects demographic, housing, social, and economic data every year. To provide reliable estimates for small counties, neighborhoods, and population groups, the ACS provides 1-, 3-, and 5-year aggregate estimates. Estimates for this report are from aggregated data from 2010-2014.

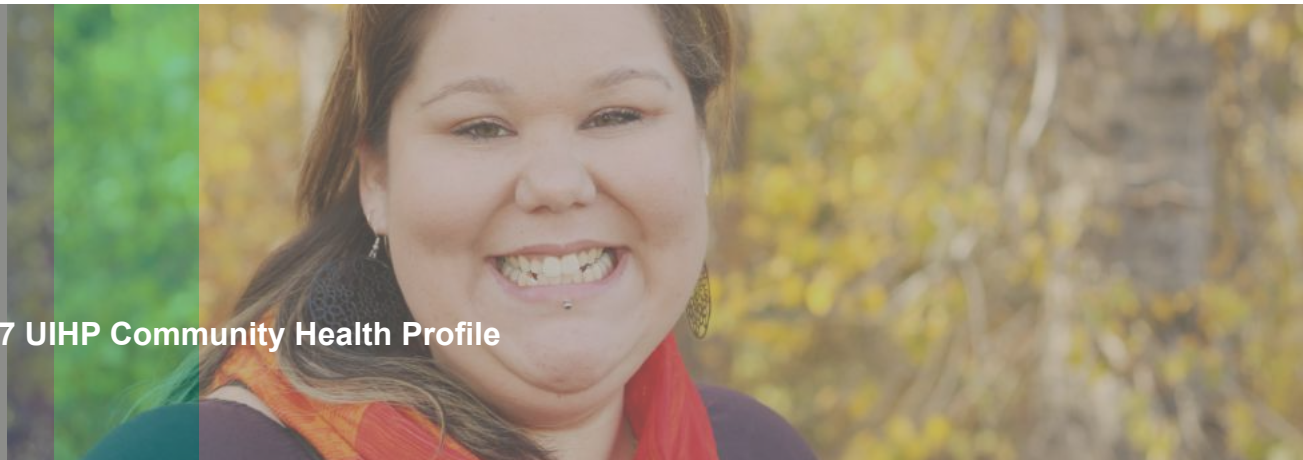
Race is self-reported on ACS, with similar race categories as the U.S. Census. However, some ACS data are not easily accessible for multiple race groups. Therefore, ACS data are reported for AI/AN alone in this report. ACS estimates in this profile are not adjusted for age; observed differences in estimates may be due to a true difference in rates or due to differences in age distribution in the population.

For more information about the ACS, visit: www.census.gov/acs.

National Vital Statistics System

Mortality data from the National Vital Statistics System (NVSS) is generated from death certificates. This data is the primary source of demographic, geographic, and cause-of-death information among persons dying in a given year. The five most recent years for which complete mortality data was available was from 2010-2014. The five most recent years for which complete infant mortality data was available was from 2008-2012. Maternal mortality was only available from aggregated data from 2010 to 2012. All mortality data are age-adjusted to the U.S. population for the year 2000. Age-adjusted death rates are useful when comparing different populations because they remove the potential bias that can occur when comparing populations with different age distributions. For example, AI/ANs historically are a younger population than other race groups.

Birth certificate data from NVSS data files include all documented births occurring within the United States as filed in each state. These data include demographic information about parents, information on the infant, the mother's risk factors,



DATA SOURCES

and information on the birth. The five most recent years for which complete natality data was available was from 2008-2012.

Since not all states allow individuals to identify as more than one race, National Center for Health Statistics (NCHS) releases bridged-race population estimates for calculation of rates. As a result, estimates in this report may not match local and county estimates because of differing projection methods.

For more information about Vital Statistics, visit: http://www.cdc.gov/nchs/nvss.htm.

SOCIODEMOGRAPHICS

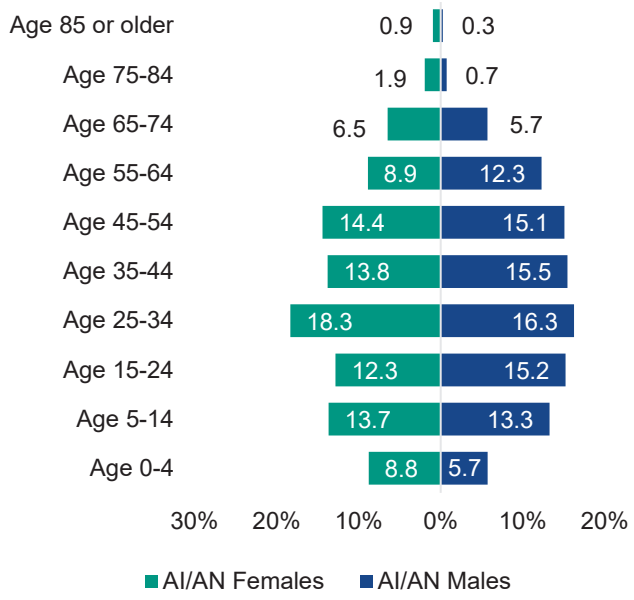
Introduction

The health of individuals and populations is greatly influenced by social determinants – the conditions in which people live, learn, work, and play.[8,9] Evidence from decades of research on the relationship between key social determinants and health outcomes overwhelmingly suggests that greater social disadvantage leads to poorer health.[10] These determinants, including race, lack of access to education or employment, poverty, and housing, among other things, produce extensive inequities within and between populations.[8,9] This section presents data on measures of demographics and social determinants of health to illustrate differences between urban AI/ANs and NHWs that may contribute to overall health inequities between these populations.

Age and Gender

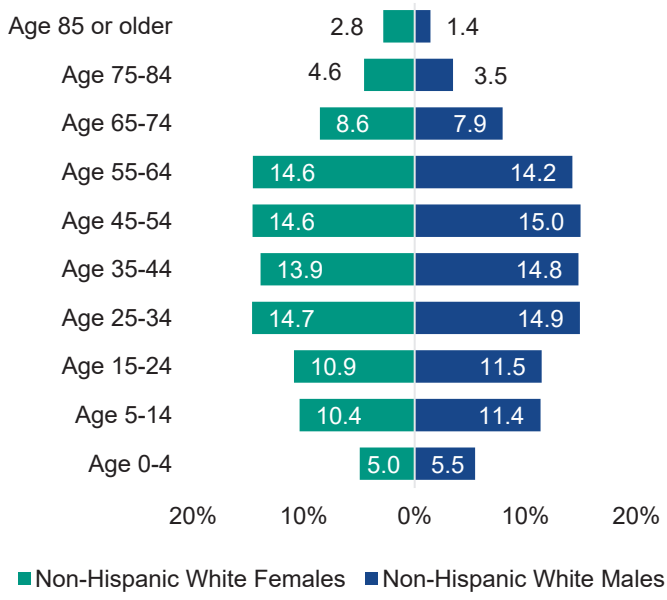
Relative to the NHW population, the AI/AN population in Portland service areas was younger (Figure 1 and Figure 2). In all Portland service areas combined, 37.4% of AI/ANs were under the age of 25 years, compared with 27.2% of NHWs. In contrast, 8.0% of AI/ANs were over the age of 65 years, compared with 14.4% of NHWs.

Figure 1. AI/AN Population by Age and Gender, Portland Service Area, 2010-2014

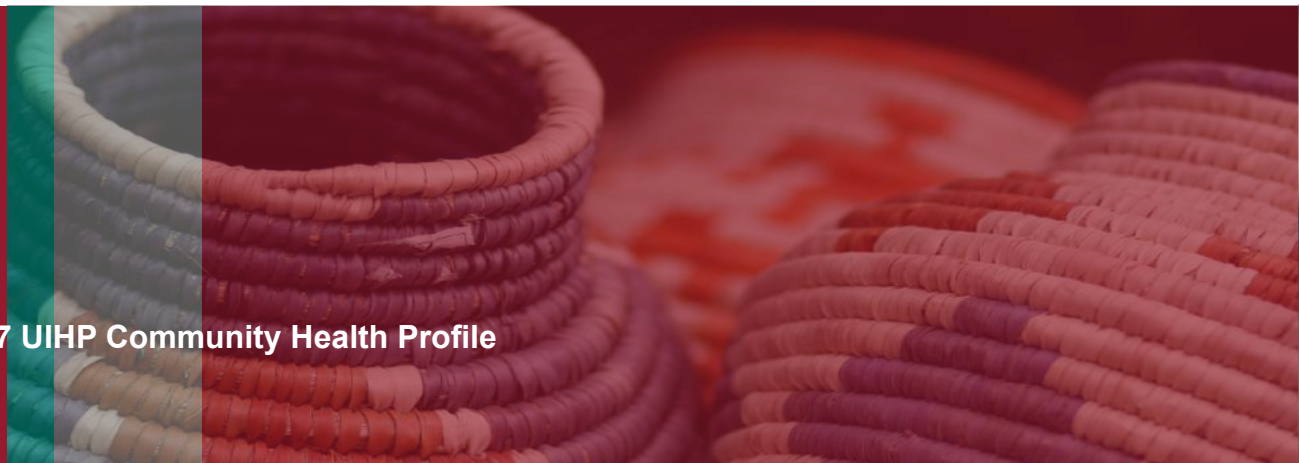


Source: American Community Survey, 2010-2014

Figure 2. NHW Population by Age and Gender, Portland Service Area, 2010-2014



Source: American Community Survey, 2010-2014

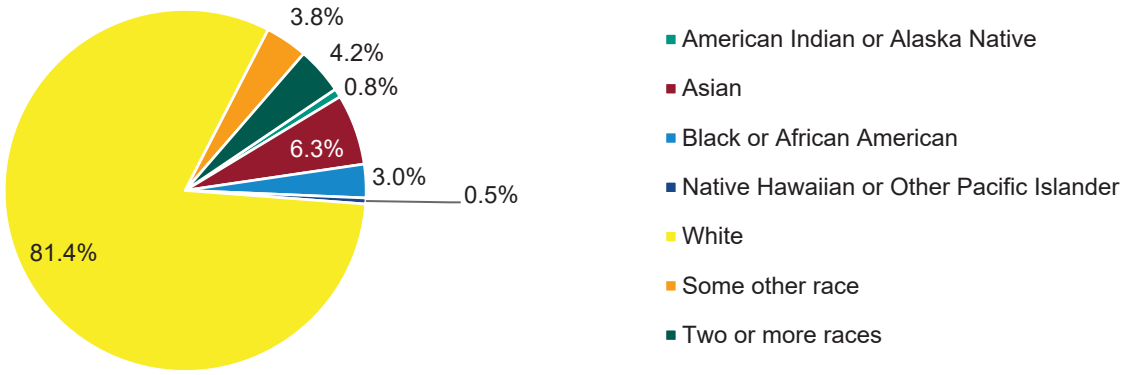


SOCIODEMOGRAPHICS

Race

As shown in Figure 3, an estimated 16,674 (0.8%) individuals identified as AI/AN alone in all Portland service areas combined, and an estimated 44,683 (2.1%) individuals identified as AI/AN alone or in combination with one or more races (data not shown). Those who identified as White alone comprised the largest proportion (81.4%) of the total population (2,127,791) in Portland service areas. Asians alone were the second largest population identified in Portland service areas, consisting of 134,715 individuals or 6.3% of the total population.

Figure 3. Population by Race, Portland Service Area, 2010-2014

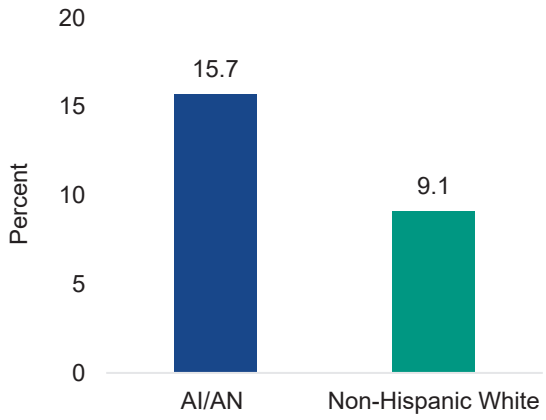


Source: American Community Survey, 2010-2014

Employment

Extensive evidence has shown that unemployment has a negative effect on health.[11] Unemployed individuals may experience financial insecurity and reduction in social status, social relations, and self-esteem.[12] In addition, unemployed individuals are also more likely to lack health insurance coverage.[13] In all Portland service areas combined, AI/ANs aged 16 and older experienced unemployment 1.7 times as much as NHWs (15.7% vs. 9.1%; Figure 4). These proportions do not include individuals in the military or individuals who are institutionalized.

Figure 4. Civilian Labor Force 16 Years and Older, Portland Service Area, 2010-2014



Source: American Community Survey, 2010-2014

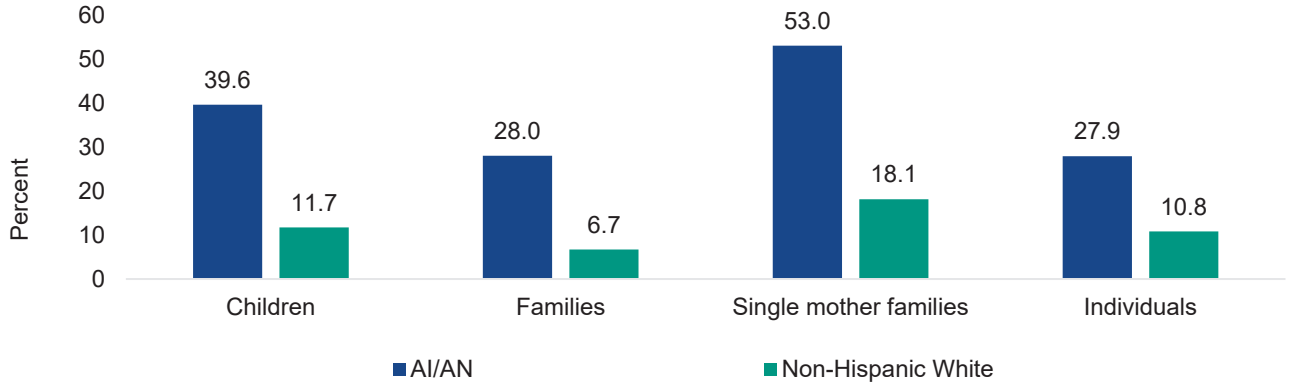
SOCIODEMOGRAPHICS

Poverty

Poverty and health are inextricably connected.[14] Poverty may lead to poor health outcomes by limiting access to healthy foods, quality housing, safe neighborhoods, and adequate health care, among other things. Poverty can also impact many aspects of a child's health and well-being. Children in poverty have lower academic achievement and higher rates of high school dropout, accidents, injuries, and food insecurity compared with their more affluent peers. Living in poverty as a child likely affects health throughout a person's lifespan.[15] The American Community Survey defines individuals and families as being in poverty if their income is less than their poverty threshold (less than 100% of the federal poverty level).[16]

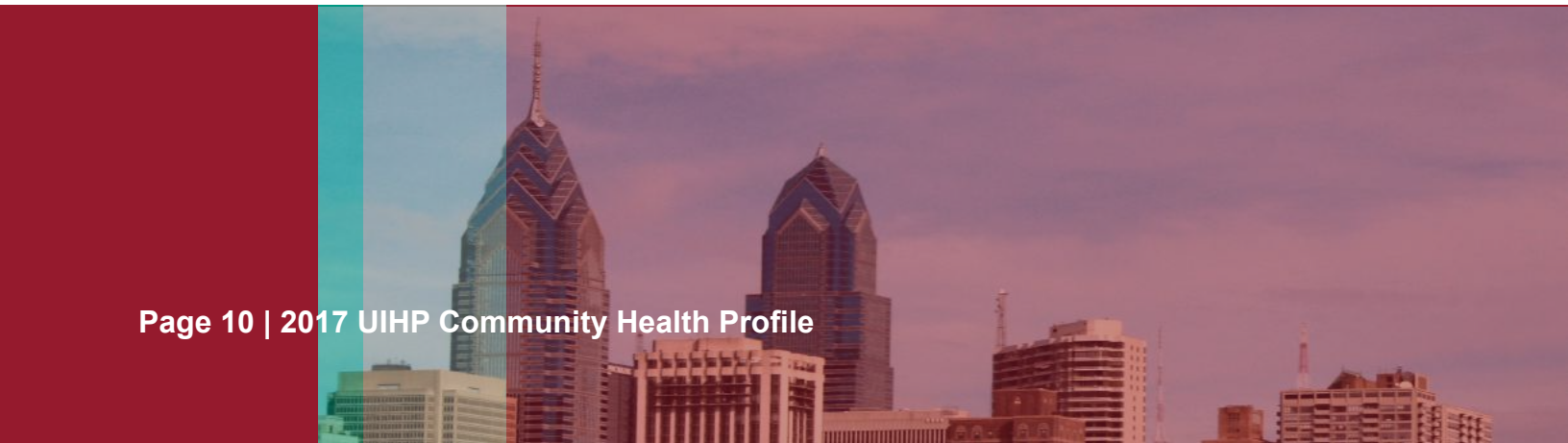
In all Portland service areas combined, more than a quarter of AI/AN individuals lived in poverty (27.9%; Figure 5), compared to just one tenth for NHWs (10.8%). Approximately two in five AI/AN children aged 17 and under (39.6%) in all Portland service areas combined lived in households with an income below the federal poverty level, 3.4 times the proportion of NHW population (11.7%). In addition, more than one in four AI/AN families in all Portland service areas combined (28.0%) lived in households with an income below the federal poverty level; 4.2 times the relative proportion of NHWs (6.7%). The proportion of single-mother households among AI/ANs living in poverty (53.0%) was 2.9 times the proportion among NHWs (18.1%).

Figure 5. Income Below the Federal Poverty Level in Past Year, Portland Service Area, 2010-2014



Source: American Community Survey, 2010-2014

Data note: Federal poverty thresholds are used to determine poverty status. The thresholds are based on family size and the ages of family members. Federal poverty thresholds are not intended as a comprehensive description of families' needs, but rather as a statistical indicator that can be tracked over time.

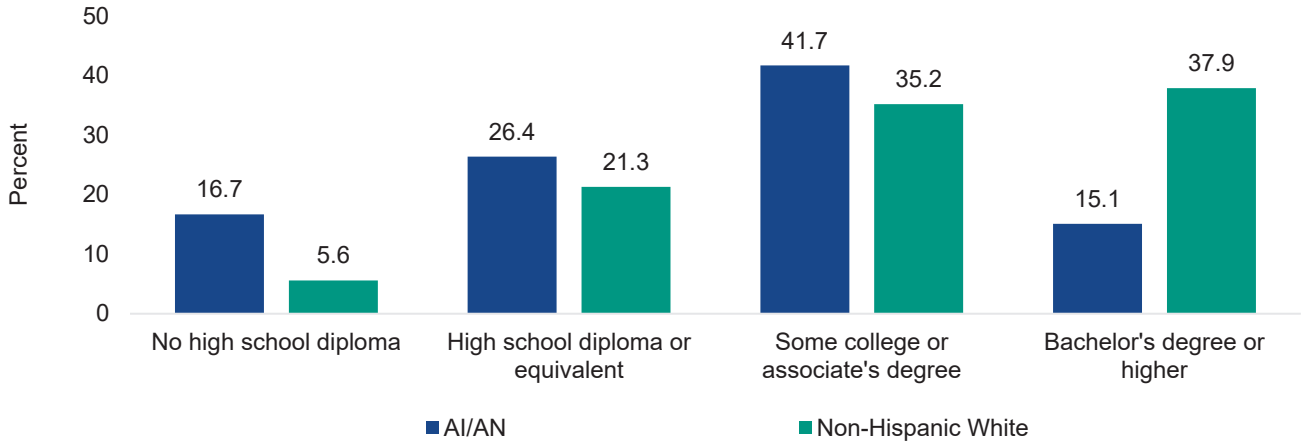


SOCIODEMOGRAPHICS

Educational Attainment

The relationship between education and health, or the "health-education gradient," is well documented.[17] Significant disparities in life expectancy by level of education are found among all demographic groups and are arguably increasing over time.[18] In all Portland service areas combined, a significantly higher percentage of AI/ANs aged 25 and older had not completed high school or passed the General Educational Development (GED) exam (16.7%; Figure 6) compared with the NHW population (5.6%). A significantly lower percentage of AI/ANs (15.1%) reported an undergraduate or graduate degree as their highest level of education compared with the NHW population (37.9%).

Figure 6. Educational Attainment for the Population 25 Years and Older, Portland Service Area, 2010-2014



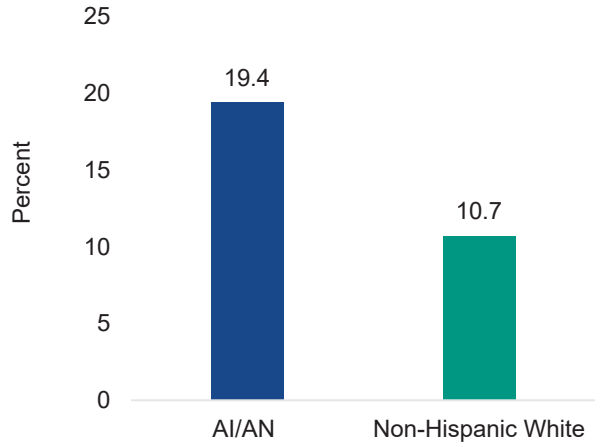
Source: American Community Survey, 2010-2014

SOCIODEMODEMOGRAPHICS

Health Insurance Coverage

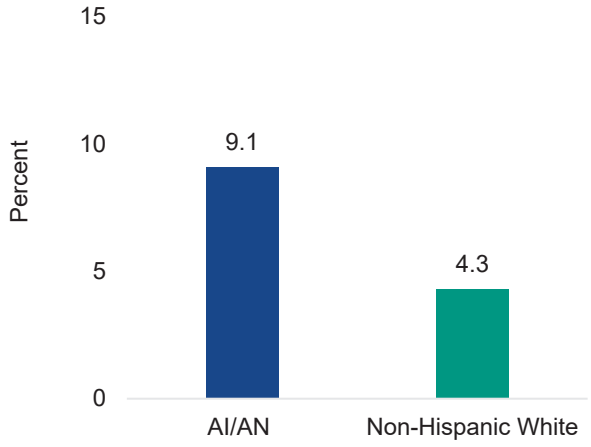
Compared to those with health insurance coverage, those without health insurance coverage have higher mortality rates.[19] Individuals without health insurance are also less likely to receive care and take longer to return to health after an unintentional injury or the onset of a chronic disease compared to those with health insurance.[20] In all Portland service areas combined, one in five AI/ANs under age 65 (19.4%) reported having no health insurance,1.8 times the proportion of NHWs (10.7%; Figure 7). The proportion of uninsured AI/AN children under the age of 18 in all Portland service areas is 2.1 times higher than the proportion of NHW children (9.1% vs. 4.3%, Figure 8).

Figure 7. Population Under 65 with No Health Insurance Coverage, Portland Service Area, 2010-2014

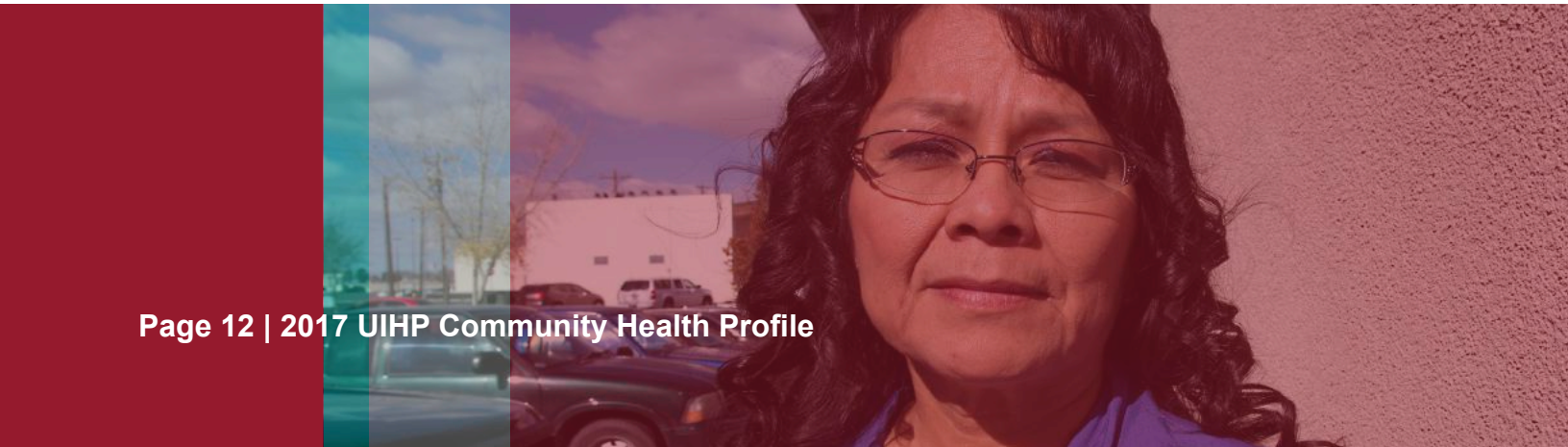


Source: American Community Survey, 2010-2014

Figure 8. Population Under 18 with No Health Insurance Coverage, Portland Service Area, 2010-2014



Source: American Community Survey, 2010-2014



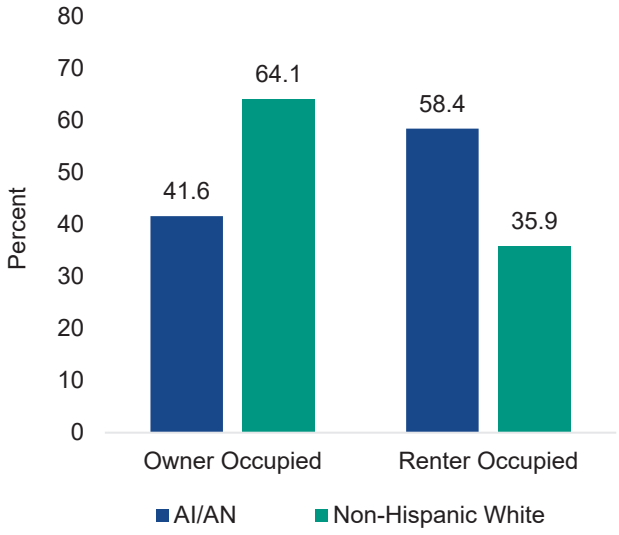
SOCIODEMODEMOGRAPHICS

Housing

Housing and health are also closely linked. Several studies have found that home ownership is associated with many health benefits, including greater psychosocial wellbeing and lower mortality risk. These benefits may be explained by the fact that homeowners likely experience higher socioeconomic status, fewer problems of overcrowding, and lower exposure to neighborhood violence. In contrast, renters are more likely to experience poorer self-reported health, higher rates of coronary heart disease, and more risk factors, such as smoking.[21]

In all Portland service areas combined, the proportion of renter occupation among AI/ANs was 1.6 times that of NHWs (58.4% vs. 35.9%, Figure 9). Over half of all homes of AI/ANs were renter occupied, compared with approximately one-third of homes for NHWs. In contrast, the proportion of home ownership among NHWs in all Portland service areas combined was 1.5 times higher than among AI/ANs (64.1% vs. 41.6%). Less than half of all homes of AI/ANs were owner occupied, compared with nearly two-thirds of homes for NHWs.

Figure 9. Type of Occupied Housing Units, Portland Service Area, 2010-2014



Source: American Community Survey, 2010-2014

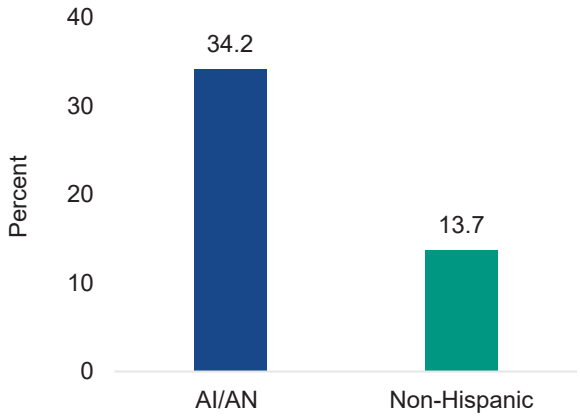
SOCIODEMODEMOGRAPHICS

Food Stamps

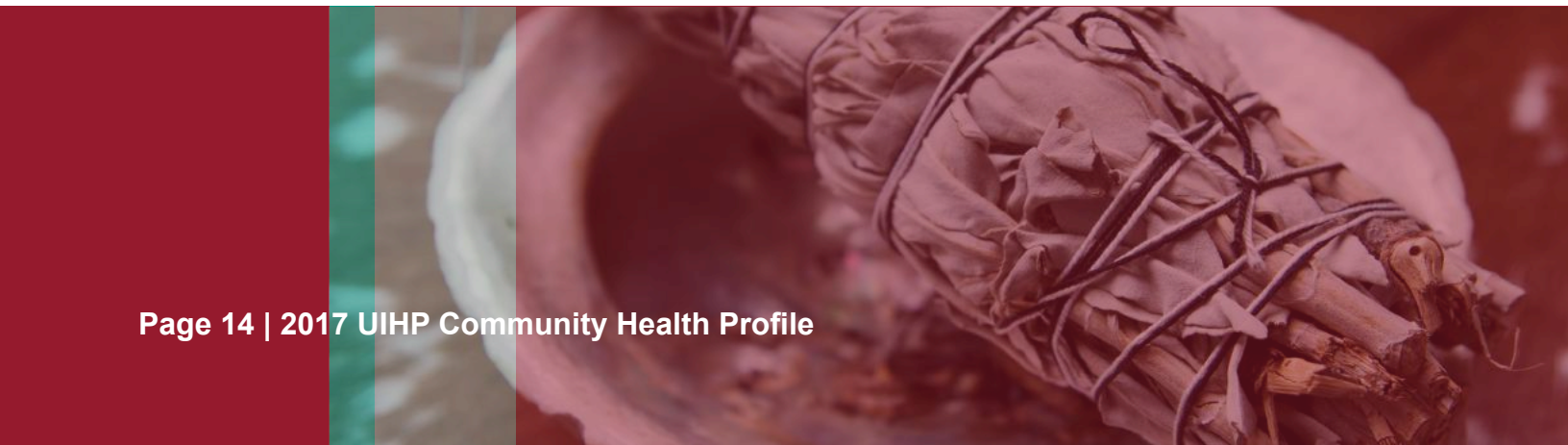
As the largest food assistance program in the United States, the Supplemental Nutrition Assistance Program (SNAP; formally known as the federal Food Stamp program) is a crucial part of the social safety net.[22] Households with an income below 130% of the federal poverty level are eligible to receive SNAP benefits. According to a study done by the U.S. Department of Agriculture, which administers the SNAP program, 55% of households receiving SNAP benefits remained food insecure after receiving SNAP.[23] Moreover, children in households that receive SNAP benefits are more likely to suffer from an array of health problems than those in households that do not receive SNAP.[22]

In all Portland service areas combined, one third of AI/AN households received SNAP benefits in the past year (Figure 10). The proportion of SNAP participation among AI/ANs in these areas was 2.5 times the relative proportion of NHW.

Figure 10. Households that Received SNAP Benefits in the Past Year, Portland Service Area, 2010-2014



Source: American Community Survey, 2010-2014



MORTALITY

Introduction

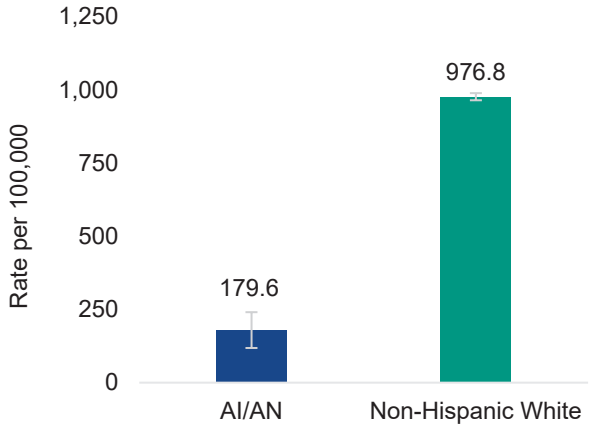
Mortality data provides an indication of a community's or population's health and socioeconomic development status. Mortality data are also a key component in understanding population size, future growth, and change. Examining mortality data is one way to measure the burden of disease in a community or population. Tracking death rates may identify groups that are at an increased risk for premature death and may identify specific diagnoses resulting in death that are more prevalent in certain populations. In addition, high mortality rates may indicate an issue with environmental factors, communicable diseases, risk factors, and/or socioeconomic factors.

This section examines age-adjusted mortality by race, gender, age groups, and specific causes of mortality. It is important to note that racial misclassification leads to an underestimation of mortality rates in AI/AN populations.[24] True mortality rates among AI/ANs in Portland service areas are assumed to be higher than the rates described for this section.

All-Cause Mortality Rate

All-cause mortality rate for the AI/AN population was 81.6% lower compared to NHWs (Figure 11).

Figure 11. All-Cause Mortality Rate, Portland Service Area, 2010-2014

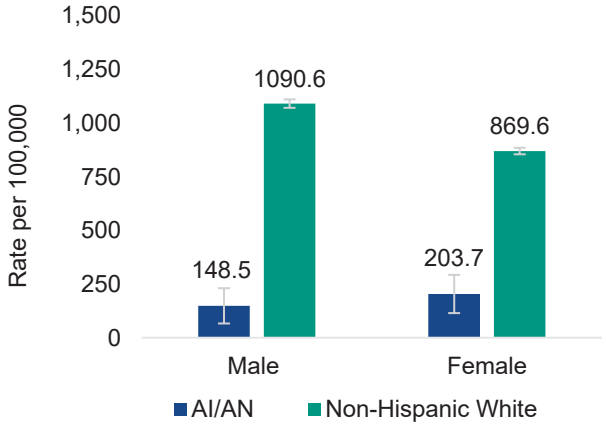


Source: US Center for Health Statistics, Death Certificates, 2010-2014

Mortality Rate by Gender

The mortality rates for AI/AN males and females were lower than their NHW counterparts at 86.4% and 76.7% respectively (Figure 12).

Figure 12. Mortality Rate by Gender, Portland Service Area, 2010-2014



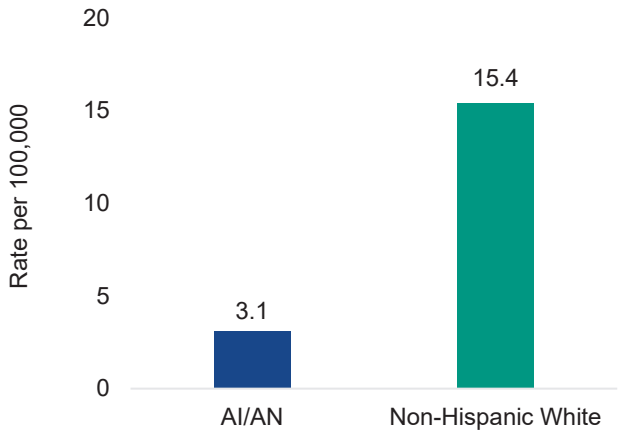
Source: US Center for Health Statistics, Death Certificates, 2010-2014

MORTALITY

Suicide

The suicide rate for NHWs was significantly higher (5.0 times) compared to AI/ANs (Figure 13). NHWs experienced suicide at a rate of 15.4 suicides per 100,00 compared to AI/ANs who had rates of 3.1 per 100,000.

Figure 13. Overall Suicide Rate, Portland Service Area, 2010-2014



Source: US Center for Health Statistics, Death Certificates, 2010-2014

MORTALITY

Top Causes of Mortality

Table 1. Causes Top of Mortality, Portland Service Area, 2010-2014

AI/AN			NHW		
Rank	**Cause**	**Rate (per 100,000)**	**Rank**	**Cause**	**Rate (per 100,000)**
1	Vascular disease	253.6	1	Vascular disease	887.3
2	Cancer	59.9	2	Cancer	459.4
3	Diabetes	38.2	3	Chronic lower respiratory disease	107.0
4	Flu and pneumonia	8.4	4	Alzheimer's disease	77.2
5	Chronic liver disease and cirrhosis	6.6	5	Flu and pneumonia	73.5

Source: US Center for Health Statistics, Death Certificates, 2010-2014

Table 1 summarizes the top causes of mortality for both AI/AN and NHW.

Table 2. Top Male Causes of Mortality, Portland Service Area, 2010-2014

AI/AN Males			NHW Males		
Rank	**Cause**	**Rate (per 100,000)**	**Rank**	**Cause**	**Rate (per 100,000)**
1	Cancer	34.5	1	Vascular disease	314.9
2	Vascular disease	32.2	2	Cancer	253.1
3	Diabetes	16.7	3	Chronic lower respiratory disease	53.4

Source: US Center for Health Statistics, Death Certificates, 2010-2014

Table 2 summarizes the top causes of mortality for both AI/AN and NHW men.

MORTALITY

Table 3. Top Female Causes of Mortality, Portland Service Area, 2010-2014

AI/AN Female			NHW Females		
Rank	**Cause**	**Rate (per 100,000)**	**Rank**	**Cause**	**Rate (per 100,000)**
1	Vascular disease	103.6	1	Vascular disease	243.7
2	Cancer	25.0	2	Cancer	193.3
3	Diabetes	20.1	3	Chronic lower respiratory disease	48.1
4	Flu and pneumonia	7.0	4	Alzheimer's disease	34.3
5	Chronic liver disease and cirrhosis	5.9	5	Flu and pneumonia	29.9

Source: US Center for Health Statistics, Death Certificates, 2010-2014

Table 3 summarizes the top causes of mortality for both AI/AN and NHW women.

MATERNAL AND CHILD HEALTH

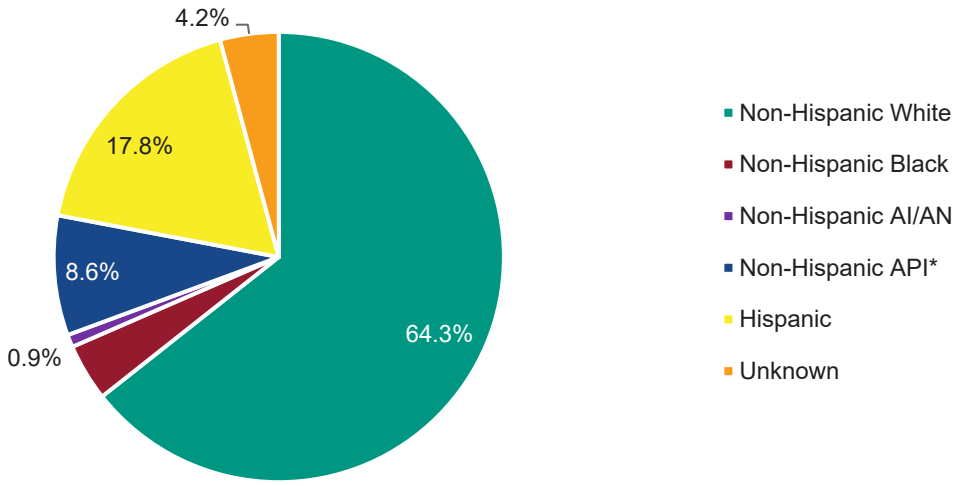
Introduction

Maternal and child health (MCH) is the foundation for healthy children, mothers, and families. Monitoring indicators such as maternal smoking, gestational diabetes, prenatal care, and premature births can help NARA make decisions regarding programs that impact pregnant mothers, newborns, and infants. This section of the community health profile focuses on key indicators for MCH. The data can be used to further examine why these disparities exist and consider programs to eliminate these health disparities.

Total Births

From 2008 to 2012, there were a total of 115,356 births in Portland service areas. Among those births, 0.9% were identified as non-Hispanic AI/AN alone (Figure 29). The largest proportions of births among racial/ethnic group were from NHW (64.3%) and Hispanic (17.8%) women. Non-Hispanic Blacks were 4.1% and non-Hispanic Asians and Pacific Islanders were 8.6% of all births.

Figure 14. Births by Race/Ethnicity, Portland Service Area, 2008-2012



Source: National Vital Statistics, Birth Certificates, 2008-2012

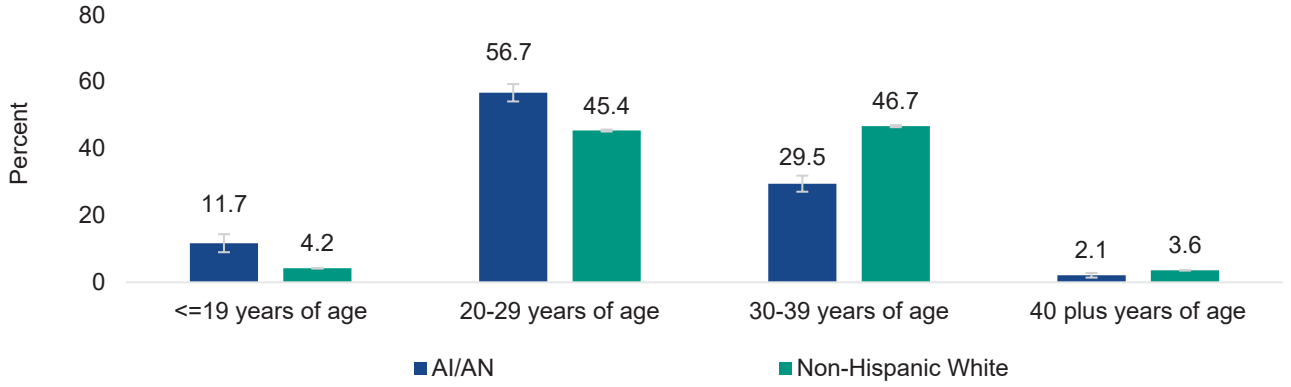
*API-Asian/Pacific Islander

MATERNAL AND CHILD HEALTH

Age

In general, AI/AN women tend to give birth at younger ages than their NHW counterparts (Figure 15). The proportion of AI/AN women in Portland service areas (less than 19 years of age) giving birth (11.7%) was 2.8 times higher than NHW teenagers (4.2%). In addition, approximately 56.7% of all births among AI/AN women were to women in their 20s, compared to 45.4% among NHWs. There was a higher proportion of births among NHW women in their 30s compared to AI/AN women. Approximately 46.7% of all births among NHWs were to women in their 30s, whereas approximately 29.5% AI/AN births were to women in their 30s.

Figure 15. Births by Maternal Age Group, Portland Service Area, 2008-2012

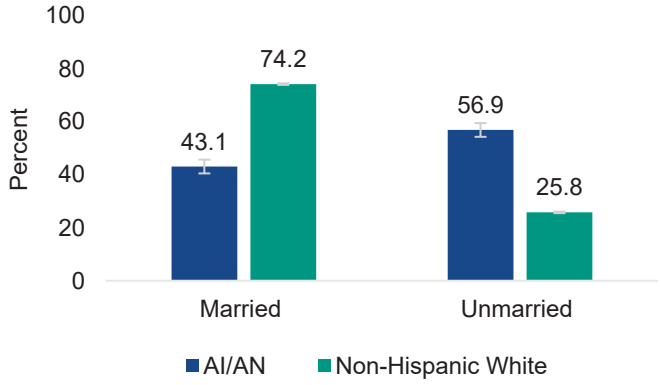


Source: National Vital Statistics, Birth Certificates, 2008-2012

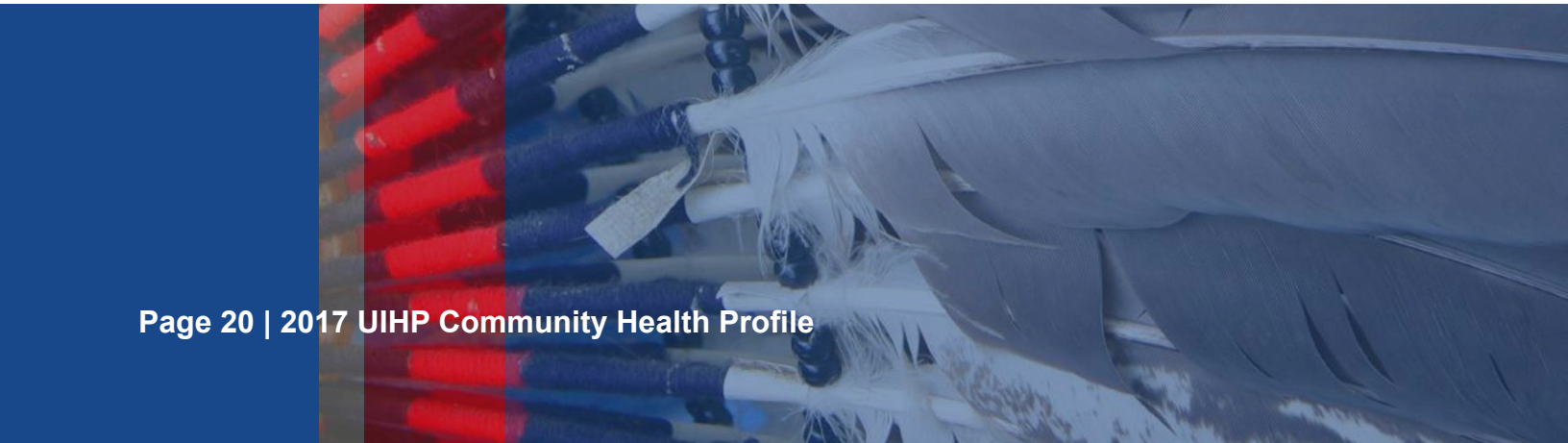
Marital Status

Approximately 43.1% of all births to AI/ANs in Portland service areas were to women who were married and approximately 56.9% were to women who were not married (Figure 16). This was significantly different compared to NHWs in which 74.2% of births were to married mothers and 25.8 were to unmarried mothers. The proportion of births to unmarried AI/AN women was 2.2 times greater compared to their NHW counterparts.

Figure 16. Births by Marital Status, Portland Service Area, 2008-2012



Source: National Vital Statistics, Birth Certificates, 2008-2012

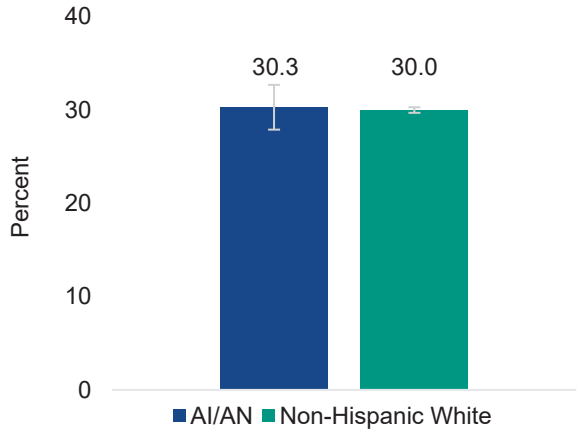


MATERNAL AND CHILD HEALTH

Cesarean Section

In Portland service areas, approximately one third of births were delivered by cesarean section among NHW females. This was similar to the proportion of deliveries by cesarean section among AI/AN births (30.3%, Figure 17).

Figure 17. Births by Cesarean Section, Portland Service Area, 2008-2012

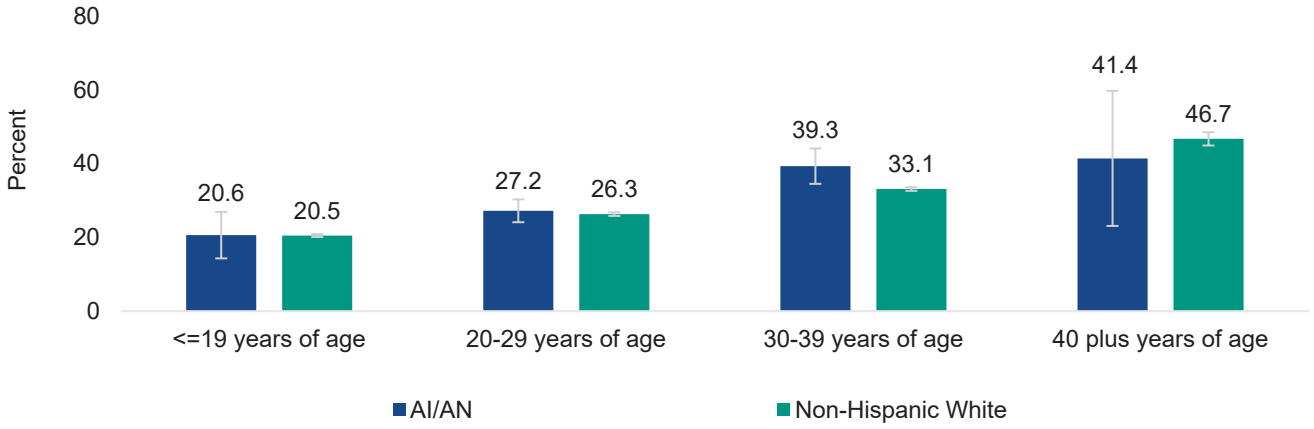


Source: National Vital Statistics, Birth Certificates 2008-2012

Cesarean Section by Maternal Age

The proportion of cesarean deliveries generally increased as maternal age increased for both AI/AN and NHW women (Figure 18).

Figure 18. Cesarean Sections by Maternal Age Group, Portland Service Area, 2008-2012



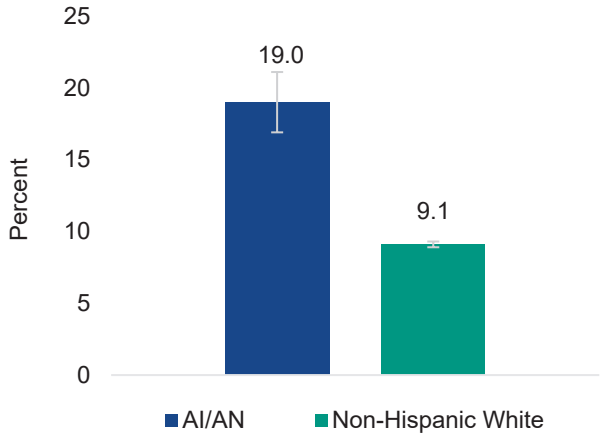
Source: National Vital Statistics, Birth Certificates, 2008-2012

MATERNAL AND CHILD HEALTH

Maternal Smoking

In Portland service areas, 19.0% of AI/AN women smoked while pregnant, compared to 9.1% NHW women (Figure 19). The proportion of AI/AN women smoking while pregnant was 2.1 times higher than NHW women.

Figure 19. Maternal Smoking, Portland Service Area, 2008-2012

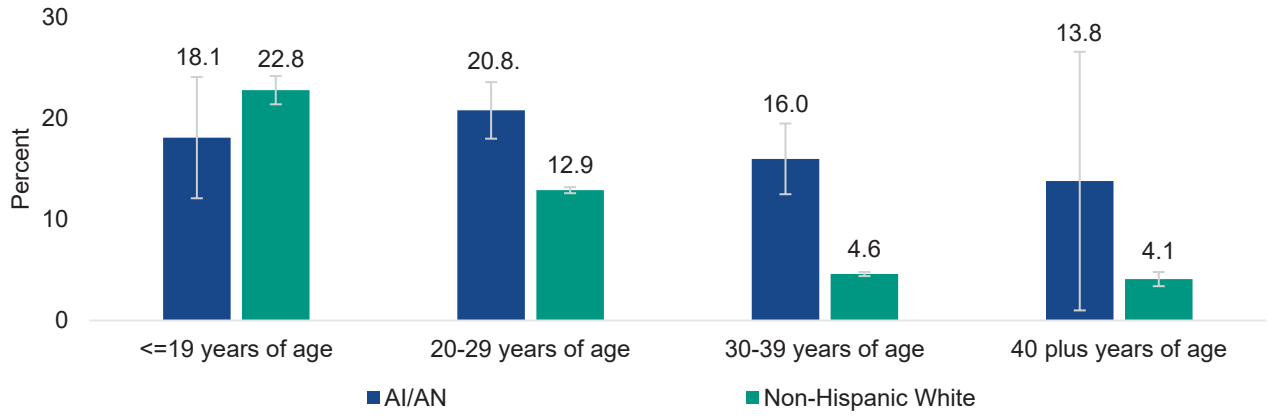


Source: National Vital Statistics, Birth Certificates, 2008-2012

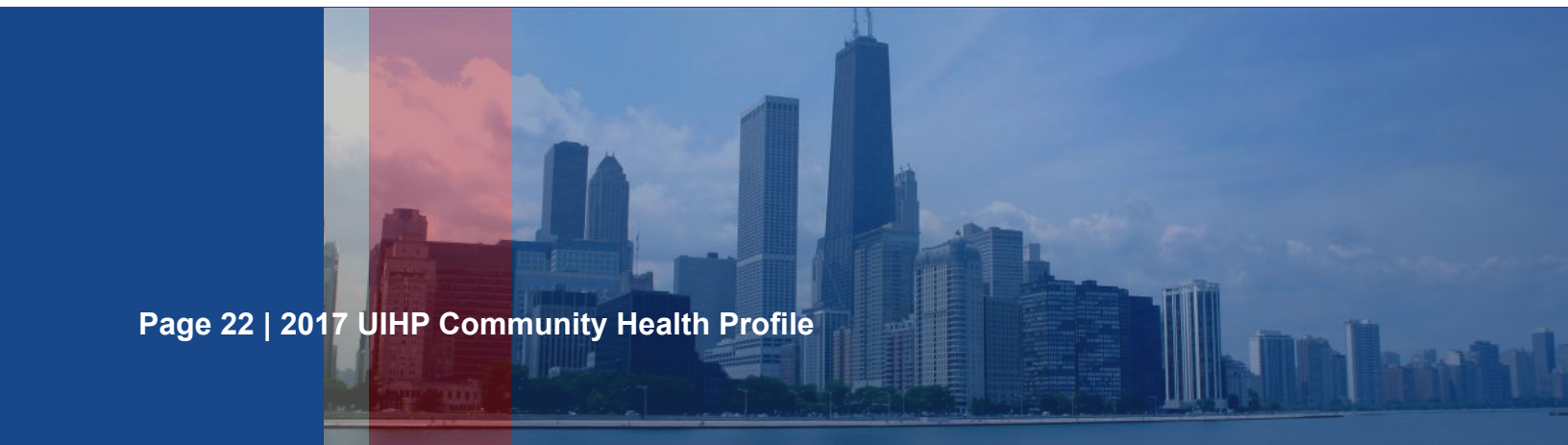
Smoking by Maternal Age

Maternal smoking decreased as maternal age increased for NHW (Figure 20); showing that age was a risk factor for maternal smoking in NHW women. Maternal smoking was significantly higher among AI/AN women in their 20s, & 30s, compared to NHW women.

Figure 20. Maternal Smoking by Age Group, Portland Service Area, 2008-2012



Source: National Vital Statistics, Birth Certificates, 2008-2012



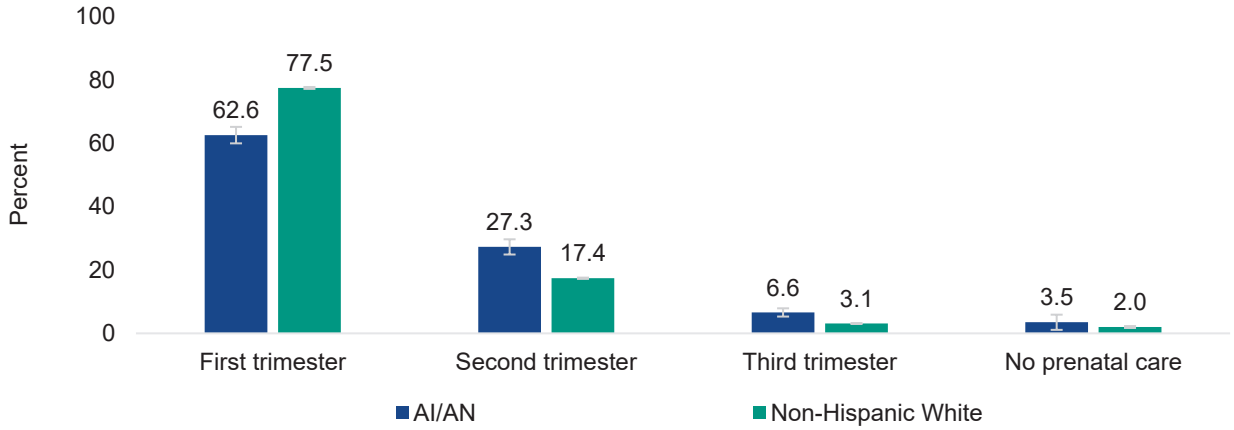
MATERNAL AND CHILD HEALTH

Prenatal Care

Prenatal care refers to the medical attention received by women before or during their pregnancy, specifically addressing the mother's well-being during her pregnancy and caring for the development of her baby. The goal of prenatal care is to detect potential problems early on in the pregnancy and to prevent potential complications. Early prenatal care is a significant component in ensuring a good pregnancy outcome and it is recommended for women to begin prenatal care during the first trimester. Women who receive late or no prenatal care are at risk for having undetected complications during their pregnancy that can result in severe maternal morbidity and mortality, and serious consequences to the unborn infant including low birth weight, premature birth, morbidity and mortality.[25]

Among pregnant women in the Portland service areas, 62.6% of AI/AN women began prenatal care in the first trimester compared to 77.5% of NHW women, a significant difference (Figure 21). The proportion of NHW women beginning prenatal care in the first trimester was approximately 1.2 times higher than AI/AN women. Of pregnant AI/AN women, 10.1% began prenatal care in the third trimester or did not receive any prenatal care during their pregnancy compared to 5.1% of NHW pregnant women. The proportion of AI/AN women beginning prenatal care in the third trimester or not receiving any prenatal care during their pregnancy was 2.0 times the proportion of their NHW counterparts.

Figure 21. Prenatal Care by Trimester, Portland Service Area, 2008-2012



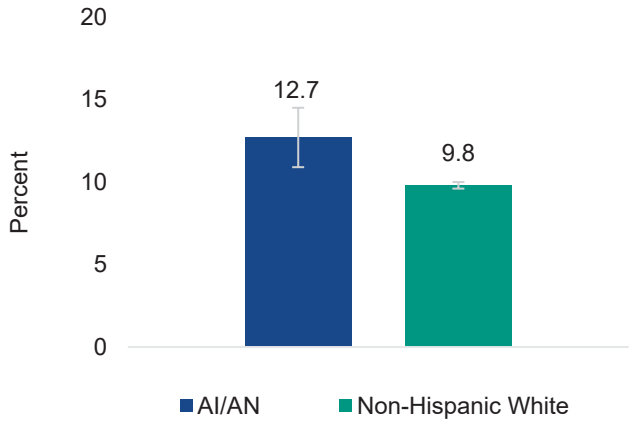
Source: National Vital Statistics, Birth Certificates, 2008-2012

MATERNAL AND CHILD HEALTH

Premature Births

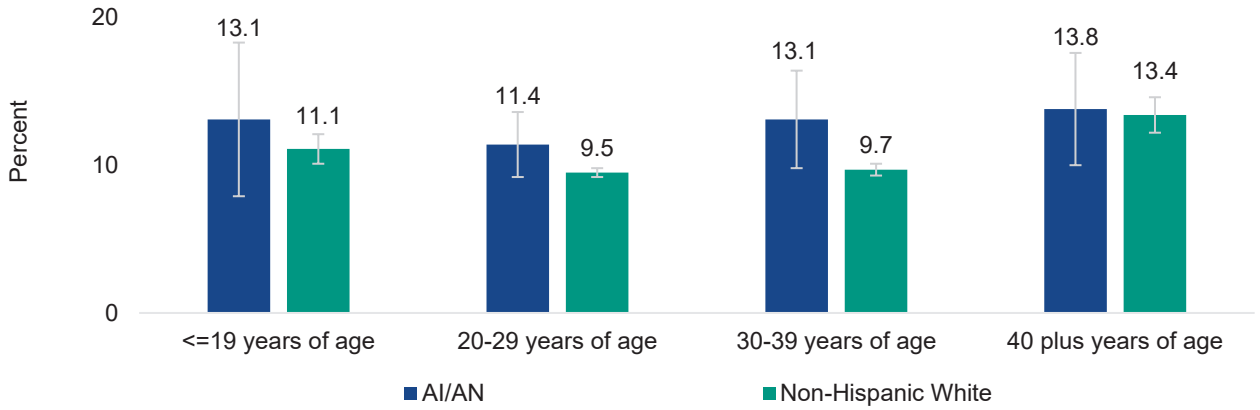
A premature birth is defined as childbirth occurring earlier than 37 completed weeks of pregnancy.[26] In Portland service areas, approximately 9.8% of all infants born to NHW women were born prematurely, which is significantly lower than all infants born prematurely to AI/AN women at 12.7% (Figure 22). The proportion of premature births was 1.3 times higher among AI/AN compared to NHW women. Patterns of premature births were similar for both NHW and AI/AN pregnant woman by age stratification (Figure 23). Premature birth rates were relatively consistent across maternal age for AI/ANs.

Figure 22. Premature Births (<37 weeks), Portland Service Area, 2008-2012

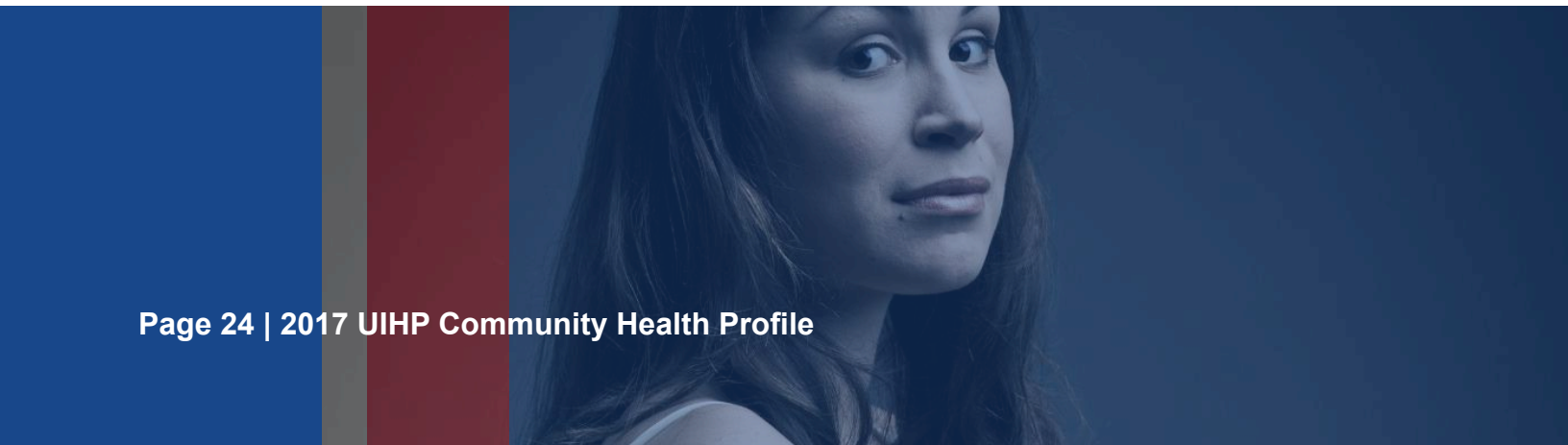


Source: National Vital Statistics, Birth Certificates, 2008-2012

Figure 23. Premature Births (<37 weeks) by Maternal Age Group, Portland Service Area, 2008-2012



Source: National Vital Statistics, Birth Certificates 2008-2012

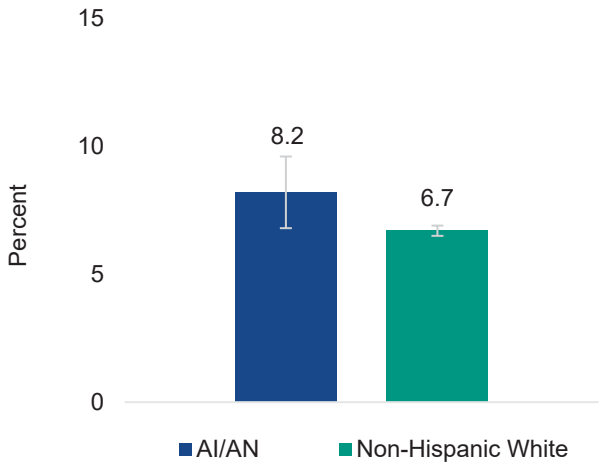


MATERNAL AND CHILD HEALTH

Low Birth Weight

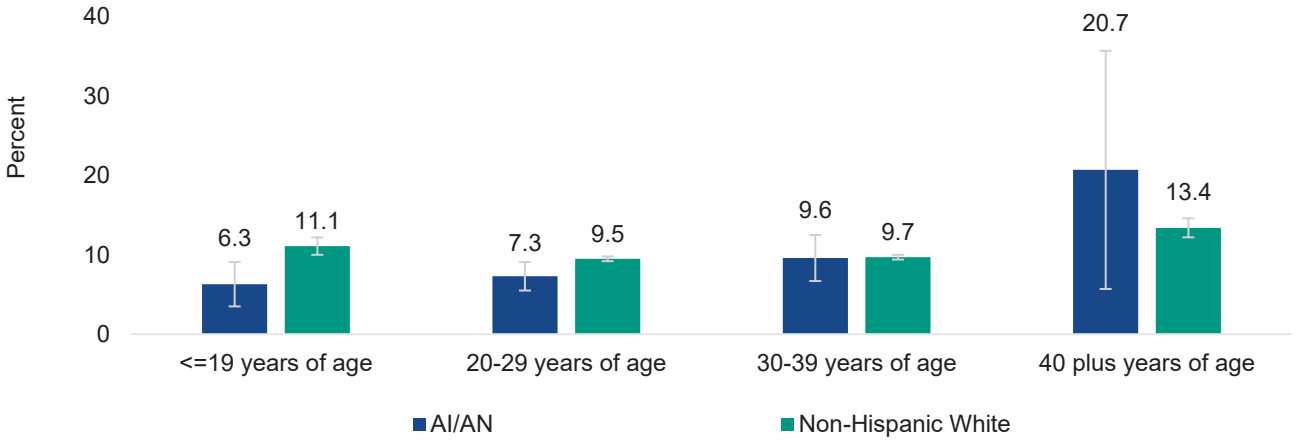
Low birth weight is defined as less than 2,500 grams (5.5 pounds).[27] In Portland service areas, 8.2% of all infants born to AI/AN women were low birth weight, which was slightly higher than the proportion of all low birthweight infants (6.7%) born to NHW women (Figure 24). The proportion of AI/AN women giving birth to a low birth weight infant was 1.2 times the proportion of NHW women. Low birth weight patterns by age stratification were similar for pregnant women from both AI/AN and NHW categories (Figure 25).

Figure 24. Low Birth Weight (<2,500 g), Portland Service Area, 2008-2012



Source: National Vital Statistics, Birth Certificates, 2008-2012

Figure 25. Low Birth Weight (<2,500 g), by Maternal Age Group, Portland Service Area, 2008-2012



Source: National Vital Statistics, Birth Certificates 2008-2012

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APPENDIX

Glossary of Terms

ACS – American Community Survey

AI/AN – American Indian / Alaska Native

IHS – Indian Health Service

MCH – Maternal and Child Health

NARA – Native American Rehabilitation Association

NCHS – National Center for Health Statistics

NHW – Non-Hispanic White

NICU – Neonatal Intensive Care Unit

NVSS – National Vital Statistics System

SNAP – Supplemental Nutrition Assistance Program, commonly referred to as Food Stamps

TEC – Tribal Epidemiology Center

UIHI – Urban Indian Health Institute, a division of the Seattle Indian Health Board

UIHP – Urban Indian Health Program

APPENDIX

About Us – Our Mission & History

The mission of UIHI is to support the health and well-being of urban Indian communities through information, scientific inquiry, and technology.

The UIHI was established as a Division of the Seattle Indian Health Board, a community health center for urban American Indians and Alaska Natives (AI/ANs). The UIHI is one of 12 tribal epidemiology centers (TECs) funded by the Indian Health Service (IHS). While the other 11 TECs work with tribes regionally, the UIHI focuses on the nationwide urban AI/AN population. As a crucial component of the health care resources for all AI/ANs, tribal epidemiology centers are responsible for:

- Managing public health information systems
- Investigating diseases of concern
- Managing disease prevention and control programs
- Communicating vital health information and resources
- Responding to public health emergencies
- Coordinating these activities with other public health authorities

Contact Information

For general questions, please contact: info@uihi.org

UIHI distributes a Weekly Resource Email – if you would like to be included in our subscription to receive updates, you can email the address above.

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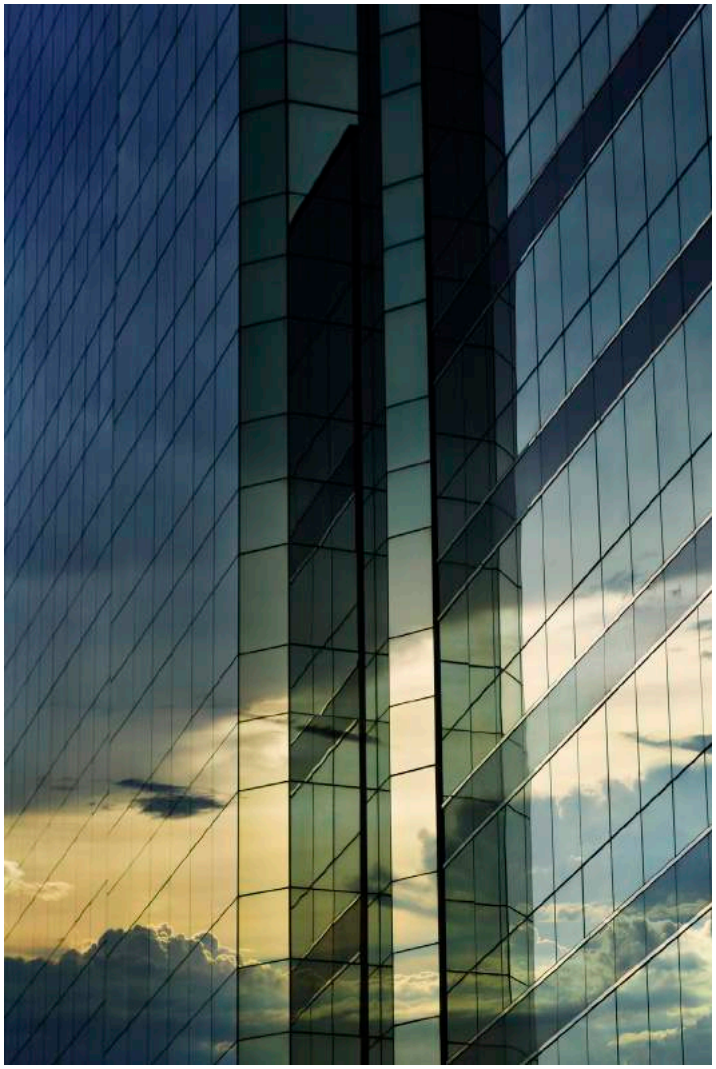

Contact Us

Please contact the Urban Indian Health Institute with your comments by emailing info@uihi.org, calling (206) 812-3030 or visiting us online at www.uihi.org.

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