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# Barriers to dermatologic care for American Indian/Alaskan Native individuals at urban Indian organizations

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To the Editor:

American Indian/Alaskan Native people make up approximately 9.7 million (2.9 %) of the U.S. population [1]. In 1976, Title V of the Indian Health Care Improvement Act was passed to provide funding for the IHS Office of Urban Indian Health Program (UIHP). Urban Indian Health Program funds Urban Indian Organizations (UIOs) throughout the U.S. to provide ambulatory care for urban American Indian/Alaskan Native patients [2]. Despite this effort, urban American Indian/Alaskan Native individuals continue to face health disparities. Compared with urban whites, urban American Indians/Alaskan Natives experience significantly higher death rates for all top-5 leading causes of death (heart disease, cancer, unintentional injury, diabetes, and chronic liver disease), [3]. American Indian/Alaskan Native women are less likely to receive adequate prenatal care compared to whites living in the same metropolitan areas [4].

Even though an estimated 70% of American Indians/Alaskan Natives live in an urban area, little is known about access to dermatologic care in this population. A statewide emergency department database analysis in California, where the largest percentage of American Indian/Alaskan Native population is found, shows American Indian patients are more likely to visit the ED for dermatology concerns than white patients as well as all other minority groups [5]. It is unclear whether this is due to disparity in access to outpatient dermatologists, a difference in distribution of urgent dermatologic issues, or another factor.

This provider survey aims to better understand barriers to dermatologic care for individuals receiving care through urban Indian organizations and providers' interest in dermatology teleconsulting. This study was determined to be exempt from review by both the University of Washington Human Subject Division and the Indian Health Service National Institutional Review Board (NIRB) under 45 CFR 46.101(b)(2). Inclusion criteria include a) health care providers (MD/DO, Physician Assistant, Advanced Practice Registered Nurse) who are employed at an urban Indian organization (UIO), b) urban Indian organizations must meet Indian Health Care Improvement Act (IHCIA) requirements as well as, c) provide medical care and/or referral services based on website information at time of data collection. Information regarding medical care and specialty referral services were obtained from each urban Indian organization's website.

Surveys were distributed to providers by the medical director or clinic manager at each clinic across 31 Urban Indian Organizations between March 2021 to June 2021 or September 2021 to October 2021. Data collection was split up into two separate periods in attempts to not overburden providers and clinic staff during the COVID-19 surge. Data were anonymously collected and stored in REDCap. Descriptive statistics were performed in Microsoft Excel.

Thirty-one urban Indian organizations in 9 service areas out of 41 UIOs in 11 service areas met inclusion criteria. Data was collected from 31 providers across

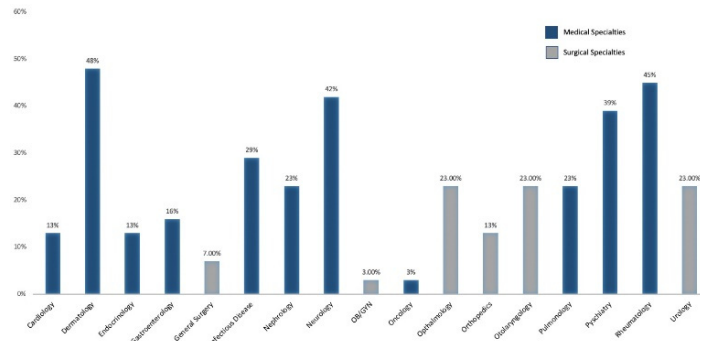
**Table 1.** Provider and patient panel demographic data (N=31). The majority of providers were MD/DOs or Advanced Practice Registered Nurses who took care of both pediatric and adult patients. Twenty-one providers reported at least 50% of their patients were American Indian/Alaska Natives.

Provider training	No. (%) (N=31)
<b>MD/DO</b>	16 (51.6)
Family medicine	14 (45.2)
Internal medicine	1 (3.2)
Pediatric medicine	1 (3.2)
ARNP	13 (41.9)
PA-C	2 (6.5)
<b>Years of practice</b>	
<5 years	15 (48.4)
6-10 years	7 (22.6)
11-20 years	4 (12.9)
>20 years	5 (16.1)
<b>Estimated percentage of AI/NA patients on patient panel</b>	
75-100%	15 (48.4)
50-74%	6 (19.4)
25-49%	8 (25.8)
< 25%	2 (6.5)
<b>Age range of patient panel</b>	
0-12 yo	21 (67.7)
13-19 yo	25 (80.6)
20-24 yo	26 (83.9)
25-39 yo	26 (83.9)
40-60 yo	27 (87.1)
60+ yo	27 (87.1)

ARNP, advanced practice registered nurse; PA, physician assistant.

6 service areas. The majority of clinics preferred to internally distribute survey links in order to protect providers' privacy and contact information. Therefore, the number of providers at each clinic was not known and a calculated response rate was not possible. Thirty out of thirty-one providers completed the survey in its entirety. All 31 surveys were included in analyses as incompleteness in one portion did not impact the overall survey outcome.

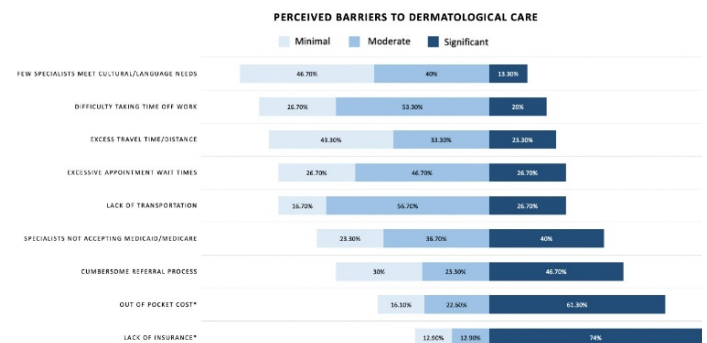
Provider and patient panel demographic data are shown in **Table 1**. The majority of participants were made up of MD/DOs (51.6%) and ARNPs (41.9%). Twenty-one out of thirty-one (67.7%) reported at least half of their patient panel was made up of American Indian/Alaskan Native individuals. The vast majority of providers took care of pediatric as well as adult patients.



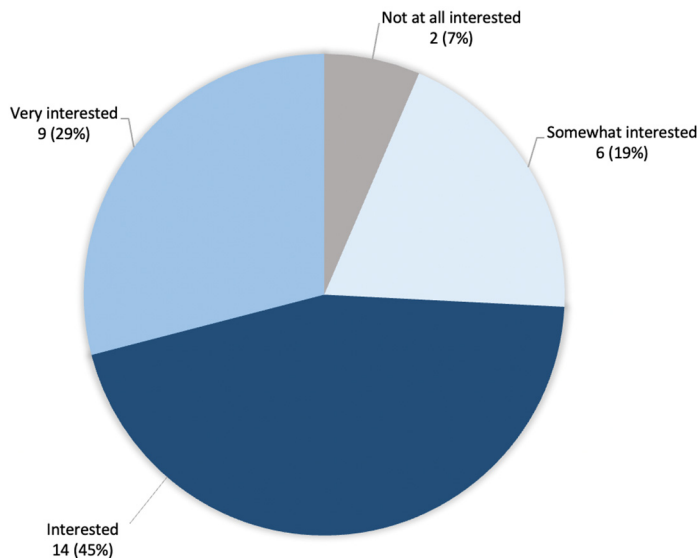
**Figure 1.** Providers rated the level of difficulty in accessing medical and surgical specialties on a 5-point Likert scale (N=31). Fifteen out of thirty-one providers (48%) reported either poor or very poor access for dermatology, which was highest among 17 specialties represented.

Providers were asked to rate the level of difficulty in accessing medical and surgical specialties on a 5-point Likert scale (**Figure 1**). Fifteen out of thirty-one providers (48%) reported either poor or very poor access for dermatology, which was highest among 17 specialties represented.

When assessing potential barriers to dermatologic care for patients at urban Indian organizations, the majority of providers reported lack of insurance (74%) and out of pocket cost (61.3%) as significant barriers to dermatologic care (**Figure 2**). The majority of providers, 74%, reported to be interested or very interested in participating in a teleconsulting program with dermatologists for management of common dermatologic conditions (**Figure 3**).



**Figure 2.** Providers rated multiple perceived barriers to dermatologic care for patients receiving care at Urban Indian Organizations as minimal, moderate, or significant (N=30; \*N=31). The majority of providers reported lack of insurance and out of pocket cost as significant barriers to dermatologic care.



**Figure 3.** Twenty-three or 74% of providers reported to be interested or very interested in a teleconsulting program with dermatologists for management of common dermatologic conditions (N=31).

This study highlights notable barriers to specialty care for patients, majority of which are American Indian/Alaskan Native individuals, receiving care at urban Indian organizations across the country. This may help explain the observed poorer health outcome such as lower melanoma survival rate and higher ED visits for dermatology concerns for American Indian/Alaskan Native patients [5,6].

Dermatology had the highest percentage of providers reporting poor or very poor access out of 17 medical and surgical specialties represented in the survey. Access to dermatology was also noted by providers as the most difficulty specialty to access in a prior study that examined access to specialty services among rural American Indian populations in Montana and New Mexico [7].

Reported poor access to dermatologic care could partially be due to a shortage of dermatologists. However, a prior analysis demonstrated that most dermatologists practice in urban areas. Therefore, undersupply of dermatologists alone may not fully account for this observation [8].

The majority of providers reported lack of insurance and out of pocket cost as significant barriers. According to a needs assessment from the U.S. Department of Health and Human Services, 56.4% of

American Indian/Alaskan Native patients who accessed urban Indian organizations in 2010 lacked health insurance [9]. For uninsured American Indian/Alaskan Native patients who live on tribal land, referral to specialty care may be covered through Indian Health Service Purchased/Referral Care (PRC) program. To be eligible for Purchased/Referral Care, patients must be residing on their reservation. Therefore, this referral process is not available for urban American Indian/Alaskan Native patients.

Although physical access to dermatologic care may not be a barrier for American Indian/Alaskan Natives in urban settings compared to those in rural communities, this study highlights persisting barriers to care for urban American Indian/Alaskan Natives. Although systemic changes are needed to address these barriers, a teleconsulting program such as Project Extension for Community Healthcare Outcomes (ECHO) may be a promising bridge to meet the needs of this patient population. Based on the results of this survey study, there may be a promising level of interest amongst urban Indian organization providers. Project ECHO has been utilized within the Indian Health Service, tribal and Urban Indian Health system to deliver hepatitis C, HIV, and tuberculosis care [10]. Project ECHO in dermatology has been carried out in states such as Mississippi, Missouri, and New Mexico to improve access for patients in rural communities.

Further expansion of the Project ECHO model in dermatology with a focus on urban Indian organizations may be a step in the right direction in improving dermatologic access for urban American Indian/Alaskan Native patients.

Limitations to this study include potential selection bias and the inability to calculate response rates given that clinics preferred to internally distribute surveys to protect the privacy of providers at each clinic. Potential for selection bias may be limited given that the participating clinics and providers were well distributed across the country in various clinical settings, training backgrounds, and level of experience. Further studies are needed to understand barriers to dermatologic care from the patients' perspective and dermatologic outcomes

for urban American Indian/Alaskan Native individuals.

Although physical access to dermatologic care may not be a barrier for American Indian/Alaskan Natives in urban settings compared to those in rural communities, multiple barriers to dermatologic care for American Indian/Alaskan Natives residing in urban areas were identified in this study. Notable barriers include lack of health insurance and out of pocket cost. Addressing financial barriers for urban

American Indian/Alaskan Native patients and expanding expert-level care in dermatology through collaboration with primary care providers at urban Indian organizations can potentially improve access to dermatologic care and disease outcomes.

### Potential conflicts of interest

The authors declare no conflicts of interest.

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