

---

---

AUGUST 2010

# Native Health Underfunded & Promises Unfulfilled

---

## The Importance of Investing in the Indian Health Service



HEALTH RIGHTS  
ORGANIZING PROJECT

NORTHWEST FEDERATION OF  
COMMUNITY ORGANIZATIONS

Nicole Soeng  
Julie Chinitz

---

---

---



## TABLE OF CONTENTS

INTRODUCTION .....	1
DISPARITIES IN HEALTH AND HEALTH CARE .....	2
Poor Health Outcomes .....	2
Poverty and Health Insurance .....	2
Discrimination and Lack of Language Access .....	3
THE POSITIVE IMPACT OF THE INDIAN HEALTH SERVICE .....	3
Overview of IHS .....	3
Role of IHS in Reducing Disparities .....	4
SEVERE, CHRONIC UNDERFUNDING OF IHS .....	6
IHS Services are Limited .....	7
Long Wait Times for Primary Medical Care .....	8
Increasing Denials for Advanced Medical Care .....	9
Effects on Urban Native People .....	10
THE IMPACT OF HEALTH REFORM ON IHS .....	11
CONCLUSION .....	12

### Acknowledgements:

The authors would like to thank Michaelynn Hawk of Indian People’s Action, Donna Polk-Primm of the Nebraska Urban Indian Health Coalition, Ralph Forquera of the Seattle Indian Health Board, Jennifer Cooper of the National Indian Health Board, and all the contributors for their assistance with this report.

---

---

## INTRODUCTION

The United States government has an obligation based on treaty and statute to meet the health care needs of Native people. However, the U.S. government has fallen far short of fulfilling this responsibility. The Indian Health Service (IHS), a federal agency, provides health care to many Native people but also has been severely and chronically underfunded. As a result, many Native people are forced to go without health care they need.

The failure to ensure access to quality health care for all Native people is especially troubling given the shocking health disparities faced by Native people, who generally live sicker and die younger than do members of other groups in the United States.<sup>1</sup> The recently enacted federal health reform legislation makes some significant improvements for Native people. However, the legislation does not provide financial resources for these improvements and leaves in place the historic underfunding of IHS. Unless Congress addresses this issue, the advances made under health reform will remain nothing more than empty promises.

To illuminate the problem of IHS underfunding, this report shares the perspectives of directors, administrators and physicians at health care organizations within the IHS system. These health care facilities deliver crucial services to Native people – many emphasizing culturally appropriate care – but often are prevented from providing needed comprehensive services because of the severe shortfall in resources.

We try to offer a one-stop shop, where patients can get all the basic health care they need. Many times our patients don't have the means to get to other places – they take the bus to our clinic – and without us, I don't think they would get basic health care. We have pretty extensive services, but we don't have enough money to provide services to the number of people who need them. We serve 16,000 patients from 224 nations, yet there are 45,000 Native people in the area, which means that we only serve one third of the Native population here.

We need more funding for additional staffing, so more people can get appointments. The average wait time for an appointment with us now is two to three months. And new patients may have to wait longer for appointments. Sometimes patients give up and end up going somewhere else. We'd like to add providers to decrease the wait time. For example, we only have one optometrist, and one full-time dentist and a part-time dentist, for 16,000 patients.

**Oklahoma City Indian Clinic,  
Oklahoma City, OK**

***Lysa Ross,***  
***Chief Operating Officer***

**Services Provided**

**Optometry**  
**Dental**  
**Medical**  
**Behavioral Health**  
**Laboratory**  
**Public Health**  
**Prevention**  
**Pharmacy**  
**Radiology**  
**Wellness Center**  
**WIC Services**

There's also a big need for more behavioral health services, like counseling and suicide prevention, and specialty services, like neurology and cardiology. But we can't provide specialty services, so we have to send patients out to non-IHS facilities through the Contract

Health Services (CHS) program. But CHS is out of funding as well, which means that they can only see the most critical cases. CHS routinely denies physical therapy and orthopedic referrals. After June, money gets even tighter and if the referred service will not "save a life" or "save a limb," it is usually denied as well.

On top of our funding shortage, we have to comply with new federal health legislation, like HITECH, which requires us to switch to electronic health records. This is costly, yet the Indian Health Service has only provided us with \$40,000 so far to do that.

We do a good job with the resources we have, but we need full funding of the Indian Health Service in order to serve everyone who needs us.

## Native People and Disparities in Health and Health Care

### Poor Health Outcomes

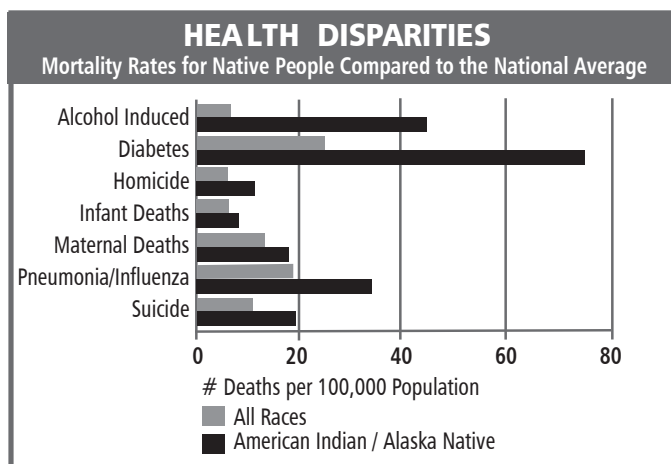
Native people fare consistently worse than many other racial/ethnic groups in the United States on a number of key health indicators. The life expectancy for Native people is 4.6 years lower than the national average.<sup>2</sup> The mortality rate for Native people is higher than the national average, and Native people are more likely to die from tuberculosis, chronic liver disease, diabetes, and pneumonia than members of any other racial/ethnic group.<sup>3</sup>

The disparities in health status that Native people face only increase their need for access to quality health care. However, Native people face many barriers to quality health care.

### Poverty and Health Insurance

Native people have a higher poverty rate than does any other racial/ethnic group in the United States.<sup>4</sup> About one third of non-elderly Native people live below the federal poverty line,<sup>5</sup> and one half of non-elderly Native people are low-income compared to only 25 percent of whites.<sup>6</sup>

Income barriers limit the ability of Native people to purchase health insurance. Only 69 percent of non-elderly Native people have health insurance.<sup>7</sup> Roughly 57 percent of Native people use IHS services,<sup>8</sup> and 16 percent rely on IHS services alone for their health care.<sup>9</sup>



U.S. Department of Health and Human Services, "Indian Health Service Disparities Fact Sheet," January 2010, <http://info.ihs.gov/Disparities.asp>.

The Menominee Tribal Clinic has been in operation since 1977. Prior to the clinic being established, patients had to access services in the surrounding communities. Patients faced discrimination and racism issues. They were required to pay for their health care and some just chose to go without.



**Menominee Tribal Clinic,  
Keshena, WI**

*Jerry Waukau,  
Health Administrator*

#### Services Provided

- Medical
- Dental
- Community Health Services
- Mental Health Services
- Wellness Center

The Clinic is managing as best as we can, as we have been forced to ration care and operate on a priority system of care. Our Medical department has grown from a three-member practice in the late 70's to a robust staff of nine providers, including seven M.D.'s and two mid-level practitioners.

The Dental Clinic is composed of four full-time dentists, three hygienists, and we have the services of our own lab technician. Waiting times for an appointment with the dentist are approximately four to five weeks.

We also operate a certified outpatient mental health program. It is staffed by three psychologists and a part-time psychiatrist. We are booked out about five weeks for the psychiatrist, and are seeing increased demand for the other providers.

More prevention dollars are needed to take care of the needs of our community. We can't continue to just take care of the crisis situations, but need to spend more in the area of preventing illnesses. We have an excellent Wellness department that is offering a number of community activities for patients.

The Clinic is heavily dependent on CHS, which covers health care services provided by doctors, hospitals, and dentists outside of the Clinic. We spend over two million dollars for CHS services.

It is important that we continue to receive increased funding from IHS to maintain our primary health care system and be able to provide more preventive services.

---

---

## Barriers Related to Discrimination and Lack of Language Access

Lack of language access presents a barrier for many Native people in obtaining quality health care. Approximately 381,000 Native people speak a North American language, yet many health centers, including IHS health centers, do not provide language services for people who speak these languages.<sup>10</sup> Lack of language services is cited by limited English proficient clients as one of the main obstacles to accessing health care.<sup>11</sup>

Additionally, Native people who do have access to health care often report being discriminated against because of their race. In a Montana study on Native health, 42 percent of those surveyed reported having a family member or close friend who faced racial discrimination when seeking medical care.<sup>12</sup> A U.S. Commission on Civil Rights investigation also conveyed reports from many Native people of discrimination and bias in the health care setting.<sup>13</sup>

## The Positive Impact of the Indian Health Service

### Overview of the IHS

IHS, an agency within the U.S. Department of Health and Human Services, provides health care to 1.9 million members of more than 564 Indian nations and Alaska Native communities in the United States.<sup>14</sup> The United States government has a legal obligation to provide health services for Native people. This obligation is the result of treaties between the federal government and Native nations, as well as federal statute.<sup>15</sup> As a reflection of this obligation, the government created IHS in 1955.<sup>16</sup>

IHS services can be provided through the federal government in IHS facilities, through tribal health facilities, or through Urban Indian Health Organizations (UIHOs) that serve Native people living away from reservations.<sup>17</sup> IHS provides vital clinical and preventive health care services and operates 645 health care facilities, including hospitals, health centers, clinics, health stations, and school-based health centers.<sup>18</sup> Additionally, when local IHS facilities cannot provide needed services for patients, they may contract out to private health care centers through the Contract Health Services (CHS) program.<sup>19</sup>

We have one health clinic, and are currently seeking to open a satellite facility soon. Without our services, many of our patients would have difficulty creating a system of health care services. As a result, the emergency room of hospitals would probably substitute as a medical home or their primary care center.

However, there are many services we cannot provide. Those services are outsourced to other health care facilities through CHS. Annually, there is a shortfall of funding, despite prioritizing CHS cases. We're trying to cut costs by bringing more services into our clinic, which will save on CHS costs. By doing so, we will be in a better position to provide CHS services throughout the year.

If we could expand our services, our first priority would be dental services. There's a host of other health issues associated with poor dental hygiene. I'd also like to create a portable health

care system, because our county covers a great distance. For many of our citizens, it's a significant event for them to get to our health offices.

With more funding, we could create a more patient-centered experience, which would include the psychological and physiological. This is one of the important aspects about IHS facilities — we're able to provide care that's culturally appropriate for American Indians. Health performance is not a magic bullet — one size doesn't fit all. Research shows that the physiology of American Indians is connected deeply with cultural practices and traditional treatments. The western health care model often does not consider the traditional healing practices of Native Americans.

We have to be resilient in our processes to survive our current economic downturn. Unfortunately, with all the promises that have been made, Native American health care continues to lag far behind. Having accessible, appropriate, affordable, and annual health care that the rest of America takes for granted every day, will allow the Native Americans to improve health status, which provides opportunities for determining ways to develop employment, education, and community participation opportunities. Working with the Pokagon Band is a pleasure and humbling.

**Pokagon Potawatomi  
Health Services, Dowagiac, MI**  
*Arthur Culpepper, PhD, FACHE*  
**Health Director**

**Services Provided**  
First Prenatal Visit  
Well Child Care  
Immunizations  
General Medical Clinic and Care  
Screening/Management Chronic Disease  
Smoking Cessation Support  
Obesity and Nutrition Counseling  
Laboratory Diagnostics  
Disease Management  
Vision Care Service

Without our facility, our patients would have trouble getting access to health care, especially dental care, because fewer and fewer dentists in Wisconsin are accepting patients with medical assistance or patients without insurance. Should additional funding become available, areas of need we would identify include: additional funding for pharmaceutical supplies, funding to expand our substance abuse and other behavioral health services, including psychiatric services. Funding to cover referral care and funding to implement Electronic Health Records is also needed.

We would like to increase the number of available hours for substance abuse counseling, but right now we just don't have enough providers. Regarding the need for psychiatric care, it sometimes takes months to get someone in for an appointment with a psychiatrist. We are currently looking into implementing a tele-health program, where our patients would be connected with psychiatrists at other centers via a telecommunication system.

The requirement to have electronic health records is coming – I believe that all health care sites need to have systems in place by 2015. Funding is needed to implement the new electronic health records requirement. We currently have to rely on grants to be able to purchase the equipment and training we need to do this. There is just not enough funding from the Indian Health Service.

CHS is the part of our budget that allows us to pay for care that we cannot provide onsite. Many people need specialized health care that we cannot provide here. There are never enough CHS dollars to cover all of the needs. Many Tribes have to prioritize care to stretch their CHS dollars. This means that sometimes people go without some specialized care because of the lack of funding.



**Stockbridge-Munsee  
Tribal Health Center,  
Bowler, WI**

***Nancy Miller-Korth,  
Health Director***

**Services Provided**  
Medical  
Dental  
Behavioral Health  
Pharmacy  
Chiropractic  
Community Health

## *Role of IHS in Reducing Disparities*

Between 2000 and 2010, on average IHS and tribally managed facilities had more than 14 million visits for inpatient, outpatient, and dental services.<sup>20</sup> In 2008, CHS covered more than 373,000 cases at non-IHS health facilities.<sup>21</sup> Furthermore, UIHOs have a patient base of 600,000 Native people living in urban areas.<sup>22</sup>

IHS services have improved the health of Native people. Since IHS expanded its diabetes services in 1993, the rate of new cases of diabetes-related kidney failure has been steadily decreasing (at the same time, rates have been increasing for African Americans and whites).<sup>23</sup> Additionally, there has been a decrease in maternal and infant deaths, deaths from tuberculosis, gastrointestinal disease, unintentional injuries/accidents, pneumonia and influenza, and alcoholism.<sup>24</sup>

One study found that, when compared with insured whites, Native people who received services from IHS showed very few differences in access for a number of indicators.<sup>25</sup> This study also found that uninsured Native people with access to IHS services were more likely than those without access to have had regular doctor and dental visits.<sup>26</sup>

IHS also plays an important role in reducing discrimination and cultural barriers faced by Native people seeking health care. According to the U.S. Commission on Civil Rights, 36 percent of the IHS staff is composed of Native people,<sup>27</sup> while nationally less than one percent of medical school graduates are Native.<sup>28</sup> This increases IHS' ability to provide culturally competent services compared to non-IHS health care facilities.



We are proud to be able to provide a variety of health related services to urban Indians throughout Nebraska and in Sioux City, Iowa. Since the Coalition was incorporated in 1986, we have slowly and strategically increased services based upon funding and community need. Our most important service is our oldest – transportation. We recognize that access to care is a problem that can result in health disparities. In FY 09 we provided 4,445 transports to medically related appointments, including WIC.

In response to the epidemic of suicide and meth use in the Indian community, we have developed a Suicide and Meth program funded through an Indian Health Service (IHS) grant. Our goal is to educate the community on risk factors and strategies to prevent suicide and drug abuse. We just had our first gang-related homicide involving Indian gang members. Although there are approximately 73 gangs in the Omaha area, this is the first time law enforcement has associated a shooting with the Native community.

Our funding streams include IHS and third party payments. The area where we are struggling is in our efforts to expand – to add pediatric, dental, x-ray, pharmacy, lab and prenatal services – because we don't have the funding for them. If we provided these services, our patients wouldn't need to access care from numerous other sources. We know that our Native families would welcome the ability to have our clinic serve as their medical home.

Our clinics – and many other clinics that serve Native people – also have problems recruiting and retaining physicians. There's a shortage of primary care physicians in many areas of the country. In frontier states like Nebraska, recruiting and retaining culturally competent physicians is particularly challenging.

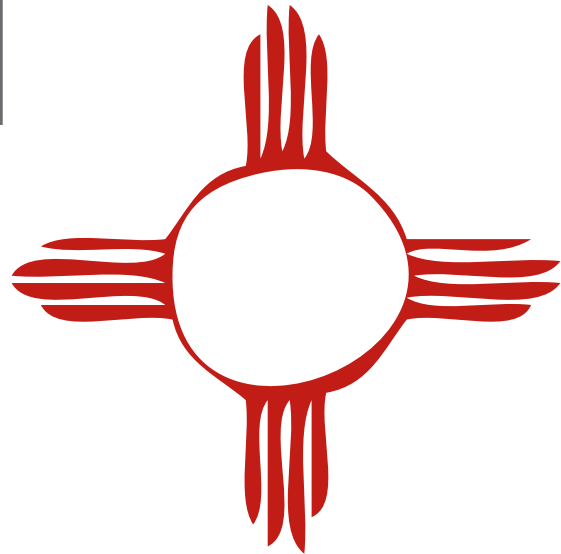
If the Indian Health Service were fully funded, we would be able to implement some of the programs we can't currently offer. And I believe there would be a direct correlation between increased funding and improved health status for Native people. If we could provide the services here without having to refer them to other facilities, there would be a substantial cost savings.

**Nebraska Urban Indian Health Coalition,  
Omaha, NE, Lincoln, NE  
and Sioux City, IA**  
*Donna Polk-Primm,  
Chief Executive Officer*

**Services Provided**  
Medical  
Behavioral Health  
Domestic Violence  
Intervention  
Diabetes Program  
Elderly Nutrition Program  
HIV/AIDS Testing &  
Counseling  
Medical Transportation  
Program

Native people consider traditional health services very important to their quality of health. One study found that Native people seeking mental health care rated traditional healing services much more effective than western medical services offered by non-Native health facilities.<sup>29</sup> Moreover, cultural competence and understanding in the provision of health care is significantly correlated to increased health quality for Native people.<sup>30</sup>

It is clear the IHS' health care services play a vital role in helping to improve the health of Native people. This is especially important given that Native people are more likely to suffer from poor health than many other racial/ethnic groups. However, in order to provide full services to all Native people who need them, IHS needs additional funding.





We are the only facility in the Central Valley that provides alcohol and drug treatment services for Native people, so without us, there wouldn't be any treatment programs in the area for Native people. Our program is severely underfunded. We haven't received an increase in funding since 1980, so we're working with only \$273,000 a year from IHS to provide drug and alcohol treatment services to 60 people a year; juvenile offender services to 40 kids a year; and outreach services to an entire county with a Native population of 9,400.

More and more, I see our people being affected by hard drugs. And along with that comes other issues like domestic violence, child abuse, car accidents caused by people driving under the influence, mental illness, and incarceration. We get Native men coming to our program who have severe mental illnesses because of alcohol and drug use. And we are the only Native health center that will take the mentally ill – no other treatment program will take them.

We try to provide the best services that we can on a shoe-string budget, but there is a lot that we cannot do because we don't have the money. Currently, we have a six-month waiting list for our alcohol and drug treatment program, so many people can't receive the services they need. Our staff is also underpaid; they're very dedicated workers, but we don't have the funding to pay them the amount that other health facilities do. This makes it hard for us to recruit staff – someone with a PhD would make a lot of money at another health facility, but they aren't going to make that much here, because we don't have the funding.

We'd like to have women's services here as well, but we don't have the funding to start anything up. Women here don't have a treatment center; they have to leave their families and go to Oakland for treatment, which is almost 60 miles away. The services we are able to provide to women are our referral services, and a weekly women's sweat lodge.

I would like to see the IHS take into consideration the alcohol and drug treatment programs when they're making their budgets. I don't recall a year where they've ever really considered the alcohol and drug programs in this process. I know everyone's in the same boat with IHS dollars, but I would love to see IHS fully funded, and then maybe they would fully fund the alcohol and drug programs, like ours. We're trying to do the best we can on a shoe-string budget and the only thing I can say is the people who are living around us are very supportive.

**Three Rivers Lodge,  
Manteca, CA**  
*Ramona Valadez,  
Executive Director*

---

**Services Provided**  
Men's Alcohol & Drug  
Treatment  
Juvenile Offender Services  
Outreach Services

## Severe, Chronic Underfunding of IHS

Despite the importance of IHS, it has consistently been underfunded compared to other public health care programs, such as Medicare and Medicaid. In 2005, the federal government spent only \$2,130 per capita for IHS beneficiaries, compared to \$5,010 for Medicaid and \$7,631 for Medicare beneficiaries respectively.<sup>31</sup>

After adjusting for inflation and population growth, the amount of funding IHS received annually steadily decreased from 1993-2007.<sup>32</sup> The Northwest Portland Area Indian Health Board calculated that the cumulative effect of the funding decreases during those years resulted in a loss of \$2.55 billion.<sup>33</sup>

The National Indian Health Board estimates that IHS would need \$21.2 billion to meet the primary health care needs of all its eligible members.<sup>34</sup> President Obama has requested to increase appropriations for IHS by 8.7 percent to \$4.4 billion in FY 2011.<sup>35</sup> Although \$4.4 billion still would not allow IHS to provide comprehensive services to all eligible people, it would take IHS a step closer to reaching the goal of full funding.

In the meantime, underfunding has caused IHS to limit the number of patients it serves and the kinds of services it provides. These limits and reductions in services are discussed further in the following sections.

Our patients come from nearly 200 federally recognized tribes, more than 20 State recognized tribes, and many non-affiliated Indians (those who are not eligible to enroll in a federally recognized tribe). Our Traditional Health Liaison assists Indian clients with traditional healing access, cultural competence training for the community, and other traditional experiences. Without our services, our patients would not receive comprehensive care, preventive services, culturally appropriate assistance, community support, and assistance with social factors that also influence health.

Additionally, we host the only accredited family medicine physician residency training program in the nation that directly contributes to culturally competent patient care through hands-on physician training in our clinic. We currently have placed 18 of our 25 graduates in Indian health sites across the nation.

Finally, we oversee the only national urban Indian epidemiology program, the Urban Indian Health Institute. This program provides scientifically sound study of health disparities among urban Indians leading to standards for defining problems and raising the visibility of urban Indian health needs to policy and decision makers.

If we got additional funding, we would direct the majority of it to new strategies for better service. Most notable, we would increase our outreach efforts and community-based screening and treatment services. Since there is not a defined geographic place where Indians live in most cities and since transportation is often difficult and limited, finding ways to take services to the community makes more sense if we are to achieve health improvement. We'd also certainly support and expand our adult dental care since the waiting list for dental services is generally months long.

The health of Indian people goes beyond just offering direct medical care and encompasses a culturally specific and informed approach that cannot be duplicated outside of the historic Indian Health Service experience. The Federal government has a legal and moral obligation to provide health services to Indian people that was just reconfirmed with the passage of the Patient Protection and Affordable Care Act, which included the reauthorization of the 1976 Indian Health Care Improvement Act. Funding for Urban Indian Health Organizations is an essential part of this obligation under this new authority, and the federal government should increase funding to help fully meet the needs of this growing population.



**Seattle Indian Health Board, Seattle, WA**  
*Ralph Forquera, Executive Director*

- Services Provided**
- Medical
  - Dental
  - Mental Health
  - Substance Abuse Treatment
  - Diabetes & Cardiovascular Programs
  - Domestic Violence Services
  - Maternal Care
  - WIC Services
  - Veteran's Services
  - Youth and Elder Activities
  - Traditional Health Liaison

## *IHS Services are Limited*

Generally, IHS facilities are not able to offer comprehensive health services. Because of the underfunding, most IHS facilities can provide only primary and community-based care.<sup>36</sup> These types of services include dental, medical, behavioral health, maternal health, and disease prevention services. Some IHS facilities are forced to limit their services further by only offering certain primary care services such as maternal health and behavioral health, or by cutting their hours of operation to fewer than 40 hours a week and/or limiting the hours/availability of physicians.<sup>37</sup>

Our services are very important to our patients, because many do not have any type of insurance, so I don't know where they would go to get care without us here. We could use more money to provide more comprehensive services to our patients. We get a lot of patients who are frustrated with the quality of care they are able to receive here, because it's incomplete. Many times they come to the clinic and need follow-up care from an outside source, but Contract Health Services can't cover it for them, so they have to pay for it. That's the number one problem- there's no ongoing continuity of care. And that leads to earlier mortality and the other common chronic health problems we see throughout IHS.

I'd like to expand many of our services if we had more money. Our pharmacy is under-sized and under-staffed. We only have

one pharmacist and one part-time technician and they're very busy. We could also use a diabetes or public health nurse. Our diabetes program and the limited dietary services we offer are solely funded through grant money, so if we lost that money, we couldn't provide those services.

We've been in search of a clinical director for over a year, and trying to recruit doctors is difficult. It may be due to the amount of funding we have that makes us unable to compete with other markets.

Full funding from IHS would allow us to get better health-related outcomes. It would allow us to give our patients the comprehensive care they deserve and need.

**Flandreau Tribal Health Clinic & Wellness Center, Flandreau, SD**  
*Grant McAdaragh, Wellness Center Health Director*

- Services Provided**
- Medical
  - Dental
  - Pharmacy
  - Optometry
  - Laboratory
  - Community Health
  - Diabetes Program
  - Mental Health
  - Substance Abuse Treatment

According to one study, 40 percent of Native people surveyed had a problem seeing a specialist through IHS.<sup>38</sup> The same study found that 42 percent of respondents had a problem getting care, tests, or treatment.<sup>39</sup> The report cited inadequate funding for IHS to meet patients' needs, requiring many services to be contracted out on a priority basis.<sup>40</sup>

IHS hospitals are also unable to provide the kinds of services that other hospitals can. Of the 45 IHS or tribally managed hospitals, only 19 have operating rooms.<sup>41</sup> IHS hospitals also have significantly fewer beds, inpatient services, and high-tech services compared to non-IHS hospitals.<sup>42</sup> Because of this, many IHS hospitals cannot provide surgical procedures and rehabilitative care.<sup>43</sup>

Dental services at IHS are severely underfunded as well. Approximately 90 percent of the dental services that IHS provides are basic and emergency care services, instead of rehabilitative care.<sup>44</sup> Because of this, Native people are often denied dental services such as root canals, crown and bridge, dentures and surgical extractions.<sup>45</sup>

### *Long Wait Times for Primary Medical Care*

When Native people can find the care they need at IHS facilities, many are forced to wait for extensive periods to be seen. A report by the Government Accountability Office identified average wait times of two to six months at some facilities for primary care services such as women's health care, general physicals, and dental care.<sup>46</sup>

Native people rate long wait times as an obstacle to receiving quality health care. In one survey, 67 percent of respondents reported that they rarely received a medical appointment soon at IHS, higher than the reported percentage for people enrolled in Medicaid.<sup>47</sup> Respondents were also more likely to report difficulty receiving urgent care than were Medicaid patients.<sup>48</sup>

Long wait times at IHS facilities historically have been caused in large part by a shortage of health care providers. In 2001, the vacancy rates at IHS facilities for positions such as doctors, dentists, pharmacists, and nurses ranged from eight to 23 percent, with vacancy rates for dentists at 22 percent.<sup>49</sup> IHS facilities have difficulty recruiting and retaining providers because of the lack of parity in pay with other health care centers and the remoteness of many reservations on which IHS facilities are located.<sup>50</sup>

Since our building burned down about four years ago, our clinic has been operating out of a mobile unit, and we haven't had the funding to build a new facility until now. Construction of our new clinic facility is slated to begin this summer and will be completed in 2012.

The two areas where we really need more funding are pharmacy and dental. We don't have a dental clinic, and many of our people can't get dental care in the surrounding area, because the dentists only accept a certain number of Medicaid patients.

There are no pediatric dentists in the area, so we're forced to send our patients to either Wausau or Eau Claire, and both of those are a two to three hour drive from here.

We're always short-staffed, because of a lack of funding. Right now we have two part-time doctors who work in the clinic, but we need a full-time doctor. We also need additional staff in the lab. To deal with the demand for services, our staff people wear many hats. Our Com-

munity Health Representatives provide outreach, home visits, follow-up-care, and hospital referrals through CHS. Many of our people rely on CHS for specialty care, like dialysis, bypass surgery, and diagnostic testing, but we never have enough money.

Health care is part of our treaty rights, so the federal government has a responsibility to fund it for us. If we could get full funding from IHS it would be like a gift from heaven. Right now we can only take care of emergencies and provide some pediatric care. Our budget is very low, and in the whole Bemidji area, I don't believe there's a clinic that's funded at even 50 percent of their level of need; most are funded at 40 percent, like us. I think what IHS has forgotten is that many people who utilize our services have no other access to health care, so their total care falls upon the tribal clinics.

#### **Bad River Health Services, Odanah, WI**

**Mary Big Boy,  
Health Director**

##### **Services Provided**

**Medical  
Pharmacy  
Laboratory  
Podiatry  
Ophthalmology  
Internal Medicine  
Mental Health**

I am a physician with the Ho-Chunk Nation. Using IHS funds and casino revenues, we own and operate two clinics that serve primarily Ho-Chunk Nation members, but also members of other nations like Oneida, Ojibwe, Menominee, and Nebraska Winnebago. Many of our patients are unemployed or underinsured, so without us they'd have to travel pretty far to other IHS clinics, go to the ER, or just go without.

It's important to our patients that our clinics are owned and operated by the Nation; it creates a sense of ownership. Community members know they have a place to go where there's familiarity and trust, and where they know there's a Ho-Chunk person at the front desk, and a Ho-Chunk doctor. Plus, we're local. Some of our patients can walk to the clinic.

The biggest problem we have is staffing our clinics — we can talk all we want about programs, but what makes a program successful is people. Our clinic in Black River Falls had been in good shape but has been without a second physician for almost the past three years. They haven't been able to replace him partly because it's a rural area.

At the House of Wellness, where I work, we especially need another mental health counselor — it's hard not having a full-time person here. Typically, if I have a patient who needs mental health services, the average wait time is four weeks minimum for them to get in to see a county therapist and even longer to see a psychiatrist. Two weeks is the least amount of waiting for our counselor.

In order to provide excellent patient care and services we need competent, qualified people, and in order to have good people, we need to be able to pay them. We're in a semi-rural place and there's not a whole lot else to attract someone unless you're from here or have family here — and we're also close enough to Madison and the Dells that health care providers have good opportunities elsewhere. We can't draw people to our clinics unless we can pay them a competitive salary with adequate benefits. And for that we need funding.

**Ho-Chunk Nation  
Health Dept.,  
Black River Falls,  
and Baraboo, WI**  
**Amy DeLong,  
Physician**

**Services Provided**  
Primary Care  
Community Health  
Environmental Health  
Podiatry  
Optical  
Dental  
AODA  
Mental Health Counseling  
Pharmacy

The provider shortage and consequent lengthy wait times decrease the quality of health care that Native people receive. One official at a tribal health clinic reported that many Native people delay seeking medical care until the development of an emergency because of the long wait times for appointments.<sup>51</sup> At another facility, many pregnant Native women received far fewer than the recommended number of prenatal care visits.<sup>52</sup> Such barriers only exacerbate the already poor health conditions that Native people face, including much higher overall mortality rates and infant mortality rates than the national average.<sup>53</sup>

### *Increasing Number of Denials for Advanced Medical Care*

Native people on reservations who need medical care that is not provided by a nearby IHS facility are sometimes sent to private health care centers through IHS' CHS program.<sup>54</sup> However, CHS is drastically underfunded, which means that many Native people are denied vital health care services.<sup>55</sup>

The underfunding for CHS services has grown even worse with the increasing demand.<sup>56</sup> From 2003-2008, the number of CHS services provided declined by 3,108,<sup>57</sup> while the number of denials for CHS services increased by 88 percent.<sup>58</sup> In its study of IHS facilities, the Government Accountability Office reported that "most facilities that did not offer the [medical] services on site lacked the funds to pay for them through contract care."<sup>59</sup>

The budget for CHS also includes funding for high cost medical cases through the Catastrophic Health Emergency Fund (CHEF).<sup>60</sup> CHEF cases include medical care for burn victims, motor vehicle accidents, high risk obstetrics, cardiology, and other high cost services.<sup>61</sup> However, because there is not enough funding to provide services to all CHEF applicants, more than half of CHEF cases are not funded.<sup>62</sup>

The President's request for the FY 2011 Budget would increase funding for CHS by \$83.4 million.<sup>63</sup> This additional funding would help CHS reduce denials and increase the number of services provided to Native people. However, there is still a long way to go to reach the funding level needed to provide CHS services to all Native people who need them. Underfunding for CHS means that more and more Native people are being denied needed medical care each year.



## Effects of Underfunding of IHS on Urban Native People

We operate five clinics in Montana — in Arlee, St. Ignatius, Ronan, Polson, and Elmo. Our clinics provide vital health services that our patients would not get elsewhere. If our clinics did not provide the services we do, we would have to purchase care from outside providers, and if the care is not life threatening, then it's not a priority for IHS and it often isn't funded. That is one of the reasons we have started up our clinics, because we were tired of people saying that so many health care services are not a priority.

Currently, IHS only funds us at 43 percent of our need. If we received additional funding, I would like to expand our preventive services, especially in the areas of obesity and cardiovascular health. I would also like to have new x-ray equipment and resources to upgrade information technology. We really need more behavioral health staff as well.

We need additional resources in CHS to take care of issues that our clinics are not able to provide, such as orthopedics, diagnostics, and surgical procedures. Those types of services are very limited now. Under the current policy of IHS, CHS services need to be emergent or they are not approved and that is an unacceptable way to operate a program. For example, if you have a gall bladder problem and you fail to do procedures to correct it, and you wait because it's non-emergent, then you will spend four to five times the amount of money and risk the life of the patient, when you could have done a diagnosis early on and saved a whole bunch of money and not risked the patient's life. I see that kind of thing happen with regularity.

Every day I deal with people who need health care that they can't get because of the lack of funding for IHS. I have seen people walking around with severe pain, with orthopedic malformations that were never addressed, people addicted to painkillers because they can't get procedures, people who need substance abuse treatment but can't receive it, and even people taking their own lives because of a number of factors, including depression.

If IHS were fully funded, we could provide the full spectrum of care that patients need. The health problems we see now are systemic and cyclical, and could be addressed with sufficient resources. I hope that the new health reform will have a positive effect on the health care we can provide, and will enable us to provide more services for our patients. The reauthorization of the IHCA was a monumental step — now if we can just get the agency to get on with implementing it.



**Confederated Salish & Kootenai Tribal Health Department, Arlee, St. Ignatius, Ronan, Polson, & Elmo, MT**  
**S. Kevin Howlett,**  
**Health Director**

### Services Provided

Primary Care  
Outpatient Care  
Community Health Programs  
Pharmacy  
Dental  
Physical Therapy  
Optometry  
X-ray  
Mobile MRI  
Substance Abuse Treatment  
Preventive Care

Many urban Native people live too far from reservations to access IHS facilities there, and they rely on UIHOs for their medical care.<sup>64</sup> However, only about one third of the urban Native population live in counties that are served by UIHOs, which leaves most urban Native people with no access to Indian health system facilities at all.<sup>65</sup>

UIHOs are funded through IHS and provide medical care to Native people living in 41 urban sites throughout the United States.<sup>66</sup> Yet the budget for UIHOs makes up only one percent of the total IHS budget, although it is estimated that 67 percent of the Native population live in urban areas.<sup>67</sup> This mismatch leaves UIHOs severely underfunded.

Due to the lack of funding, many UIHOs cannot provide the range of health services needed by Native people.<sup>68</sup> However, most Native people in urban areas cannot access CHS services to cover health care costs outside of IHS facilities, because they do not live within the contract health service delivery area.<sup>69</sup>


The President's request for the FY 2011 budget would increase funding for UIHOs by nearly \$2.4 million, which would help make up for the disparity in the level of funding that UIHOs have historically received.<sup>70</sup> The additional funding will allow UIHOs to increase the number of services they provide, and increase the number of patients they serve by an estimated two percent.<sup>71</sup> However, much more funding is needed to fully meet the health care needs of the growing urban Native population.

We are an Urban clinic funded through the Department of Health and Human Services Title V Program. Because we're an Urban clinic, we are even more underfunded than hospitals/clinics on reservations. We do not have funding for a lot of services that hospitals/clinics on reservations have. For example, we don't have funding for CHS, so when we refer clients out of our clinic for services we don't provide, the patients or clients have to pay for it themselves if they don't have insurance or aren't covered through Medicaid or Medicare.

We would like to have a laboratory, x-ray, dental and pharmacy, but right now we do not have the funding for the positions or providers. We have one part-time physician, but we could really use another doctor. And of course, we also need the supplies and equipment to set up those services.

If we had additional funding, we would be able to serve more patients who currently are not using our primary services. A lot more Native people are leaving reservations to move to the cities, and we don't have the funding to meet the increase in demand.

Our clinic is very important to the health of Native people in the city. IHS should provide us with full funding – it is part of the federal government's trust responsibility. Also, Native people have their own cultural beliefs, and we try to incorporate those into our services and programs. We need more staff and more funds – we get less than one million dollars a year to provide the much needed medical care in our community. We have to advocate to IHS and the various Tribes in our State that there is definitely a need for these Urban clinics.



**Indian Family Health Clinic,  
Great Falls, MT**  
*Ernestine Belcourt,  
Executive Director*

---

**Services Provided**  
Medical  
Diabetes Program  
Fitness/Wellness Program  
Behavioral Health  
Substance Abuse Treatment  
Limited Mental Health Services

PPACA authorizes IHS to continue many of its current programs and provide some new programs and services.<sup>73</sup> Specifically, the law provides IHS with new or expanded authority for services in the areas of mental and behavioral health, long-term care, dialysis, health care for Indian veterans, and Urban Indian health programs.<sup>74</sup>

The provisions in PPACA represent a positive step toward extending quality health care to all Native people. However, PPACA does not provide funding for IHS to support the provisions. Increased funding for IHS is needed or health care for Native people will remain largely unchanged. Congressional approval of the President's proposed 8.7 percent increase in FY 2011 would help narrow the disparity in funding between IHS and other health care programs, enable IHS to expand services to more Native people, and bring IHS closer to full funding.

Our services are very important for our patients — some of them have nowhere else to go for health care. Also, our patients feel comfortable coming to us, because most of our employees are of Native American descent.

We've seen an increase in funding since the Obama Administration put more money into the urban programs. This has helped us to expand our services — for example we now provide optometry services for our patients. We're also able to pay our physicians to work longer hours if we have more patients waiting for appointments, so our wait times don't get too long.

**Denver Indian Health and Family Clinic,  
Denver, CO**  
*Del Nutter,  
Executive Director*

---

**Services Provided**  
Medical  
Dental  
Diabetes Program  
Dietary  
Ophthalmology  
Optometry

Although the additional funding has been helpful, we'd still like to do more. I'd like to be able to have a pharmacy, a lab, and some basic x-ray services for our patients. Right now we have to contract out for those services, and some of them we pay for ourselves, while our patients have to pay for others. Our patients aren't covered through IHS'

CHS because we're an urban clinic, so if we can't provide them the services, they have to go to another clinic and pay for them.

I'd like to be able to provide complete health care for our patients, but to do that we'd probably need at least four times the amount we're getting now. If we got full funding, we could take care of all their health care needs here instead of sending them out for services.

## The Impact of Health Reform on IHS

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). PPACA permanently reauthorizes the Indian Health Care Improvement Act (IHCIA), which creates the framework for the Indian health system.<sup>72</sup> Prior to PPACA, the continuation of IHCIA was dependent on annual reauthorization.

We provide the best health care possible with limited funding. Our clinic is a safety net provider to other hospitals around here, and without our clinic many of our patients would be forced to pay for services elsewhere that are not culturally sensitive or go out of their comfort zone for services. Still, funding limits the quality of care we can provide our patients. Underfunding contributes to longer wait times for appointments; limited types of services, equipment, and providers; and pressing capital needs.

With additional funding we would expand our facility to address the work flow issues, improve quality of care, and increase clinic efficiencies. Our clinic space needs have adversely impacted our ability to serve more patients and the types of services we can provide. Additional funding would also be used to expand and enhance our existing services to meet the needs of our patients; this includes providing more onsite diagnostic, pharmaceutical, and other health services such as podiatry, vision, etc. With additional funding, more providers can be hired to address the wait lists for appointments.

Full funding of IHS is needed so we can effectively meet the health care need of urban American Indians, a population that is rapidly growing and predicted to continue to grow. IHS has always been severely underfunded, with urban programs being the most underfunded despite the significant changes in population trends with more American Indians moving into urban areas for increased educational, vocational, and other opportunities. Limited funding has placed IHS and consequently American Indians at a disadvantage in terms of what services they can provide and to no surprise American Indians have the highest health disparities.

The federal government has an obligation that requires it to provide quality health care at no cost to all American Indians and must assume this responsibility. Not all American Indians will or currently have health insurance. Urban Indian health programs provide invaluable culturally appropriate health services that are not available at the regular community health centers or hospitals. This goes beyond just the types of services provided by urban programs but also how they are provided (i.e., integrated holistic care). Full funding will enable urban programs to expand and enhance its services and to provide quality health services that will improve the health status of all American Indians of all life cycles.

**First Nations Community  
HealthSource,  
Albuquerque, NM**

**Linda Son-Stone,  
Executive Director**

**Services Provided**

**Medical • Family Health • Dental  
Diabetes Program  
Traditional Healing  
Massage & Acupuncture  
Reiki Therapies  
Behavioral Health  
Medicaid Enrollment  
Youth Mentoring  
Healthy Relationship Education  
HIV Prevention & Case Management  
Cardiovascular Disease Prevention  
Education  
WIC Services • Social Services  
Homeless Outreach  
Emergency Financial Assistance  
Case Management  
Supportive Housing & Case  
Management**

## CONCLUSION

The United States government has a treaty-based and statutory obligation to meet the health needs of Native people.<sup>75</sup> Native people ceded over 400 million acres of land to the United States government and in return, the government promised, among other benefits, the provision of health care services.<sup>76</sup> In 1955 the Indian Health Service was founded to advance the government's promise of providing health care to Native people.<sup>77</sup>

However, the lack of adequate funding for IHS forces many Native people to wait long periods for basic medical care and in many cases denies them access to vital medical services. Not surprisingly, compared to most other racial/ethnic groups in the United States, Native people suffer from poorer health in many key areas.

The federal government has an obligation to fully fund health care for all Native people. Congress can take a step toward meeting this obligation by adopting the President's proposed funding increase for 2011.



## NOTES

- 1 Indian Health Service, "Facts on Indian Health Disparities," viewed at: <http://info.ihs.gov/Files/DisparitiesFacts-Jan2006.pdf>. According to the IHS, "American Indians and Alaska Natives born today have a life expectancy that is 2.4 years less than the U.S. all races population (74.5 years to 76.9 years, respectively; 1999-2001 rates)."
- 2 U.S. Department of Health and Human Services, Indian Health Service, "Disparities Fact Sheet," January 2010, <http://info.ihs.gov/Disparities.asp>.
- 3 Centers for Disease Control and Prevention, National Health Statistics Report, "Health Characteristics of the American Indian or Alaska Native Adult Population: United States, 2004-2008," March 9, 2010, viewed at: <http://www.cdc.gov/nchs/data/nhsr/nhsr020.pdf>, p. 1 [hereinafter CDC].
- 4 Cara James, Karyn Schwartz, & Julia Berndt, Kaiser Family Foundation, "A Profile of American Indians and Alaska Natives and Their Health Coverage," September, 2009, p. 2 [hereinafter Kaiser Family Foundation].
- 5 Ibid.
- 6 Ibid. Low income is defined as below 200 percent of the poverty level.
- 7 Ibid, p. 7.
- 8 U.S. Department of Health and Human Services, Indian Health Service, "Disparities Fact Sheet", January 2010, viewed at: <http://info.ihs.gov/Disparities.asp>.
- 9 Kaiser Family Foundation, p. 7.
- 10 U.S. Commission on Civil Rights, "Broken Promises: Evaluating the Native American Health Care System," September, 2004, p. 37 [hereinafter U.S. Commission on Civil Rights].
- 11 Ibid.
- 12 Carrie Tracy, Northwest Federation of Community Organizations, "Montana's Urban Indians Face Health Barriers," n.d., p. 17.
- 13 U.S. Commission on Civil Rights, p. 31.
- 14 U.S. Department of Health and Human Services, Indian Health Service, "IHS Profile Fact Sheet," January 2010, viewed at: <http://info.ihs.gov/Profile2010.asp> [hereinafter IHS Profile Fact Sheet].
- 15 U.S. Commission on Civil Rights, pp. 22-24.
- 16 Ibid, pp. 23-24.
- 17 National Indian Health Board, FY 2011 Tribal Budget Recommendations to the U.S. Department of Health and Human Services, "Standing on Principles: A New Era in Tribal Government Relations," viewed at: [http://www.nihb.org/docs/10192009/Standing%20on%20Principles%20for%20Stronger%20Tribal%20Communities\\_FINAL.pdf](http://www.nihb.org/docs/10192009/Standing%20on%20Principles%20for%20Stronger%20Tribal%20Communities_FINAL.pdf), p. 5 [hereinafter NIHB, Standing on Principles].
- 18 IHS Profile Fact Sheet.
- 19 NIHB, Standing on Principles, p. 5.
- 20 IHS Profile Fact Sheet.
- 21 U.S. Department of Health and Human Services, Indian Health Service, "FY 2011: Justification of Estimates for Appropriations Committees," p. CJ-96 [hereinafter IHS Appropriations Justification].
- 22 U.S. Department of Health and Human Services, Indian Health Service, "Urban Indian Health Program Fact Sheet," January 2010, viewed at: <http://info.ihs.gov/UrbnInds.asp>.
- 23 IHS Appropriations Justification p. CJ-68. The most significant change reported was an increase in the provision of ACE inhibitors (a medication used to prevent or delay kidney failure) to Native people suffering from diabetes. See, Department of Health and Human Services, Indian Health Service, "FY 2011: Justification of Estimates for Appropriations Committees," p. CJ-68.
- 24 U.S. Department of Health and Human Services, Indian Health Service, "IHS Quick Look Fact Sheet," January 2010, viewed at: <http://info.ihs.gov/QuickLook2010.asp>.
- 25 Stephen Zuckerman, et al., "Health Service Access, Use and Insurance Coverage among American Indians/Alaska Natives and Whites: What Role Does the Indian Health Service Play?" American Journal of Public Health, January 2004, 94:1, p. 55.
- 26 Ibid, p. 56.
- 27 U.S. Commission on Civil Rights, p. 32.
- 28 Edna Francisco, "Preparing Native Health Professionals," Tribal College, Summer 2007.
- 29 Melissa Lynn Walls, et al., "Mental Health and Substance Abuse Services Preferences Among American Indian People in the Northern Midwest," Community Mental Health Journal, December 2006, 42:6, pp. 528-529.
- 30 U.S. Commission on Civil Rights, p. 32.
- 31 Donald Warne, "Ten Indian Health Policy Challenges for the New Administration in 2009," Wicaso Sa Review, Spring 2009, p10.

- 32 Northwest Portland Area Indian Health Board, "The FY 2008 Indian Health Service Budget: Analysis and Recommendations," April 13, 2007, viewed at: [http://www.npaihb.org/images/policy\\_docs/IHS/FY%202008%20Budget%20Analysis%20-%20FINAL%20April%2015,%202007.pdf](http://www.npaihb.org/images/policy_docs/IHS/FY%202008%20Budget%20Analysis%20-%20FINAL%20April%2015,%202007.pdf), p. 22.
- 33 Ibid.
- 34 NIHB, Standing on Principles, p. 7.
- 35 National Indian Health Board, "President Obama's Budget Request for the Indian Health Service (IHS) for Fiscal Year 2011," February 2, 2010, viewed at: <http://nihb.org/docs/03082010/FY%2011%20Budget%20Summary%20Snapshot.pdf>.
- 36 IHS Appropriations Justification, p.CJ-58.
- 37 U.S. Commission on Civil Rights, p. 51.
- 38 Steve R. Andersen, et al., "Measuring Performance in an Underfunded Health System: Development and Interpretation of the CAHPS for Tribal Health Systems," viewed at: <http://webcache.googleusercontent.com/search?q=cache:GxU3gYqLOWIJ:dx.confex.com/dx/8/webprogram/Handout/Paper1595/Presentation.doc+Measuring+Performance+in+an+Underfunded+Health+System:Development+and+Interpretation+of+the+CAHPS+for+Tribal+Health+Systems&cd=2&hl=en&ct=clnk&gl=us>, p.5 [hereinafter Andersen, et al.].
- 39 Ibid.
- 40 Ibid, p. 2.
- 41 IHS Appropriations Justification, p. CJ-55 and p. CJ-58.
- 42 U.S. Commission on Civil Rights, p. 52.
- 43 IHS Appropriations Justification, p. CJ-55 and p. CJ-58.
- 44 IHS Appropriations Justification, p. CJ-55.
- 45 Ibid.
- 46 U.S. Government Accountability Office, "Health Care Services are Not Always Available to Native Americans," August 2005, p. 15, [hereinafter GAO].
- 47 Andersen, et al., p.5.
- 48 Ibid.
- 49 U.S. Commission on Civil Rights, pp. 77-78.
- 50 U.S. Commission on Civil Rights, p. 78.
- 51 GAO, p.15.
- 52 Ibid.
- 53 U.S. Department of Health and Human Services, Indian Health Service, "Disparities Fact Sheet", January 2010, viewed at: <http://info.ihs.gov/Disparities.asp>.
- 54 NIHB, Standing on Principles, p. 5.
- 55 IHS Appropriations Justification, p.CJ-95.
- 56 Ibid.
- 57 IHS Appropriations Justification, p.CJ-96.
- 58 Ibid, p.CJ-95.
- 59 GAO, p. 17.
- 60 IHS Appropriations Justification, p.CJ-97.
- 61 Ibid.
- 62 Ibid.
- 63 Ibid, p.CJ-94.
- 64 Urban Indian Health Commission, "Invisible Tribes: Urban Indians and Their Health in a Changing World," 2007, p. 1 [UIHC].
- 65 Mei L. Castor, et al., "A Nationwide Population-Based Study Identifying Health Disparities Between American Indians/Alaska Natives and the General Populations Living in Select Urban Areas," American Journal of Public Health 2006, 96:8, p. 1480, viewed at: <http://ajph.aphapublications.org/cgi/reprint/96/8/1478>.
- 66 IHS Appropriations Justification, p.CJ-123.
- 67 UIHC, pp. 1-2.
- 68 Ibid, p. 7.
- 69 U.S. Department of Health and Human Services, Indian Health Service, "Health Care Away from Home Reservation," viewed at: <http://www.ihs.gov/GeneralWeb/HelpCenter/CustomServices/CHSDA.asp>.

- 70 IHS Appropriations Justification, p.CJ-127.
- 71 Ibid.
- 72 Elayne Heisler & Roger Walke, Congressional Research Service, “Indian Health Care Improvement Act Provisions in the Patient Protection and Affordable Care Act,” March 30, 2010, p. 1.
- 73 U.S. Department of Health and Human Services, Indian Health Service, “Health Reform for American Indians and Alaska Natives Fact Sheet,” viewed at: [www.ihs.gov/PublicAffairs/DirCorner/docs/Fact\\_Sheet.pdf](http://www.ihs.gov/PublicAffairs/DirCorner/docs/Fact_Sheet.pdf), p. 1.
- 74 Ibid, pp. 2-3.
- 75 U.S. Commission on Civil Rights, p. 21.
- 76 Ibid.
- 77 Ibid, p. 48



The Health Rights Organizing Project (HROP) is a collaboration of grassroots community organizations around the country. Each of the member organizations is committed to securing quality, affordable health care for all, reflecting our commitment to promoting the wellbeing of all members of our communities. We believe the call for health care for all should arise from the grassroots, with diverse leaders from across the country at the forefront. HROP is coordinated by the Northwest Federation of Community Organizations.

---

AMOS Project  
Applied Research Center  
California Immigrant Policy Center  
California Partnership  
CASA de Maryland  
Coalition for Humane Immigrant Rights of LA  
Colorado Progressive Coalition  
Connecticut Citizen Action Group  
Faith Action for Community Equity (HI)  
Granite State Organizing Project  
Grassroots Organizing (MO)  
Idaho Community Action Network  
Indian People's Action  
ISAIAH  
Jonah  
Korean Resource Center  
Mahoning Valley Organizing Collaborative  
Maine People's Alliance  
Main Street Alliance  
Make the Road NY  
Montana Organizing Project  
National Immigration Law Center  
NAKASEC  
Nebraska Appleseed  
Nebraska Urban Indian Health Coalition  
New York Immigration Coalition  
NOAH  
North Carolina Fair Share  
NE Action  
Ocean State Action  
Oregon Action  
Progressive Leadership Association of Nevada  
South Carolina Fair Share  
Sunflower Community Action  
TakeAction Minnesota  
Tenants and Workers United  
United Action Connecticut  
Virginia Organizing Project  
Western South Dakota Native American  
Organizing Project