Good Morning Chairman Calvert, Ranking Member McCollum, and Subcommittee Members:

My name is Dr. Jim Jarvis, and I am here today on behalf of the American Academy of Pediatrics, which represents 62,000 pediatricians around the country. I am the chair of the AAP's Committee on Native American Child Health, a group of leading national experts on this issue. For 50 years, the AAP has formally conducted work on AI/AN child health issues. Our Committee conducts annual site visits to review all aspects of child health at four sites in a different Indian Health Service (IHS) Area each year. Through this work, the AAP helps identify best practices for IHS to promote and replicate elsewhere, and determine key challenges to the provision of child health services in need of additional resources and support.

In addition to my role within the AAP, I am currently a professor of clinical pediatrics at the State University of New York in Buffalo. I personally have worked on American Indian and Alaska Native (AI/AN) child health issues for over 30 years. My research expertise focuses on the disproportionate prevalence of rheumatic disease among AI/AN children, and the way that trauma and toxic stress cause epigenetic changes that contribute to poorer health outcomes across the life span. I am also of Native descent myself, with Akwesasne Mohawk ancestry through my great grandmother.

I am extremely grateful for the opportunity to testify today on behalf of the AAP to discuss the critical importance of federal investment in AI/AN child health. We appreciate that through a constrained fiscal environment this Subcommittee has continued to recognize the importance of investing in the IHS and other programs serving the needs of AI/AN children. These have built upon the substantial progress in AI/AN child health indicators over the past half century, including the burden of infectious diseases and infant and child mortality.[i] However, at current funding levels there is still significant unmet need. Even with the increases in the President's proposed IHS budget, the Agency will still fall significantly short of being able to serve the health needs of AI/AN communities. This is all the more important with the knowledge that sequestration will return to IHS in FY 2016 without Congressional action. The AAP urges the Subcommittee to maintain its commitment to AI/AN child health needs in FY 2016 with strong investments in the IHS

FY 2016 Appropriations: The AAP supports the provision of at least the IHS funding requests outlined in the President's proposed FY 2016 budget, which would provide $5.103 billion in discretionary authority to IHS. The proposed budget provides a total of $3.4 billion for clinical services and $163 million for preventive health. The proposed $460 million increase above the FY 2015 enacted level would include $147.3 million for the continuation of current services by addressing factors including population growth and inflation and $313.3 million to increase support of priority IHS programming.

Challenges to the Provision of Care to AI/AN Children: The IHS has a significant task in providing both direct health services and public health programming to a service population of 2.2 million from 566 federally recognized tribes in 35 states. The predominantly rural geography of Indian Country complicates the delivery of care. The unique trust responsibility relationship between the federal government and the tribal nations requires the maintenance of federal commitment to the health care of Native Americans regardless of the federal fiscal climate. The

provision of high-quality pediatric care is critical to IHS's work. Native American children constitute a considerable proportion of the AI/AN population; over one-third of AI/ANs are under 15 years old. AI/ANs are disproportionately affected by childhood overweight and obesity, preterm birth, infant mortality, motor-vehicle related morbidity and mortality, and alcohol and drug use and their associated conditions.[ii]

Through the work I lead within the AAP and my own professional experience, I have seen firsthand the unmet health needs of Native children across all IHS service areas. During my time working in Oklahoma, I cared for a patient who experienced significant trauma. While his uncle was babysitting him and his younger sister, the uncle was huffing paint. His uncle lashed out and strangled the younger sister to death in front of my patient. This experience left an indelible and lifelong traumatic effect on this young man.

I raise this challenge to highlight the importance of supporting the work that medical and public health professionals do in Indian Country. Poverty, alcoholism, substance abuse, chronic illness, child abuse, and other poor health and social conditions are not the cause of problems in Native communities, but the symptoms of them. Every child needs safe, stable, and nurturing relationships, a healthy environment, and good nutrition. Children who experience strong, excessive, and/or prolonged adversity in childhood without the buffer of stable and supportive relationships with caring adults suffer from toxic stress. Toxic stress contributes to negative health outcomes across the life span. AI/AN children face disproportionate exposure to adverse childhood experiences, making the prevention and treatment of toxic stress and its detrimental health effects central to improving AI/AN child health.

Success in Serving AI/AN Children*:* Investing in programs to serve the health needs of Native children provides long-term benefits in the form of improved health and reduced costs. In addition to funds to provide basic health care needs, it is critical that IHS has the support it needs to ensure that AI/AN children have access to high-quality prevention and public health programming. I've watched over time in the Albuquerque Area as Tom Faber took a $5,000 Community Access to Child Health grant and turned it into a $500,000 a year operation in the Zuni Youth Enrichment Program. This past September I was on a team that visited the Seattle Indian Health Board, where we heard about their impressive Youth Ambassadors program that pairs seniors with at-risk freshmen in area high schools, which has been associated with increased attendance and a lower dropout rate in participating schools. The Family Spirit home visitation model is an additional example of a culturally-based program that promotes resilience and improves health. Home visiting is an old cultural practice, and one for which we now have evidence-based data to indicate its effectiveness.[iii] In addition, certain home visiting models have demonstrated that the benefits they generate exceed their costs.[iv]

The Special Diabetes for Indians Program is exemplary of this effect; through 2011, SDPI-supported programs were associated with a reduction in mean blood sugar levels that translates to a 40 percent reduction in diabetes related complications.[v] Through the work I do within the AAP, we began seeing the emergence of high incidence of type 2 Diabetes among AI/AN children 20 years before it became a problem nationally, and many of the strategies now used broadly are the same that first proved effective in Indian Country. Many of the health problems the IHS encounters and addresses have broad applicability to other communities across the U.S.,

and the IHS is often working on the forefront of these issues. Extrapolating solutions gleaned from IHS's work can mean savings for our entire health care system,

Advance Appropriations for IHS: Give the critical nature of the work IHS does, its significant impact on Native children, and the unique federal trust responsibility underlying this work, the AAP strongly supports the provision of advance appropriations to IHS. Advance appropriations would enable IHS to augment the value of its funding through longer term planning, improved budgeting, and better contracting options. These improvements would benefit children through better health service delivery and more cost-effective public health programming.

Advance appropriations would enable IHS to better recruit and retain pediatric health care providers. This would increase the proportion of AI/AN children receiving care from a dedicated medical home, and improve the quality of pediatric care for AI/AN children. Public health interventions that generate child health improvements would benefit from budget continuity and the improved planning it would facilitate. Dedicated people are using their creativity and passion to do amazing work in Native communities across America. This policy would generate important child health benefits without additional cost to the federal government, as demonstrated by the Veterans Health Administration since 2009.

IHS Workforce Recruitment and Retention: Effective recruitment and retention programming is central to ensuring IHS has the workforce necessary to meet the health needs of Native children. We were extremely pleased to see that the IHS budget proposal would make the Indian Health Service Health Professions Scholarship Program and Health Professions Loan Repayment Program tax exempt. Doing so would bring the status of these programs in line with the National Health Service Corps and Armed Services Health Professions scholarships. There are over 1,550 health professionals vacancies in IHS, indicating significant unmet need.[vi] Making IHS loan repayment tax free would save the Agency $5.71 million, funding an additional 115 awards.

Throughout my career, I have taught and mentored Native students interested in practicing pediatrics in Indian Country. In talking with them, it is clear to me that the burden of student loan debt is a clear and compelling factor in the decisions they make. In addition, the fact that the tax status of these programs erodes the available funding for the Agency means that fewer slots are available for health professionals who would like to serve in Indian Country. Without a sound recruitment and retention base it is difficult to cultivate the continuity of providers needed to ensure Native children receive coordinated and high-quality care in a medical home. With a budget impact of only $9.5 million, this policy offers a high-value outcome at a low cost.[vii]

Purchased and Referred Care: We were also pleased to see that the President's proposed budget included an increase of $70.3 million for Purchased and Referred Care (PRC). PRC is a critical component of the federal responsibility to provide health care for Native Americans. These funds ensure access to services not otherwise available at IHS/Tribal/Urban Indian (I/T/U) programs. However, the funds within PRC are consistently inadequate to meet the need for services. Once PRC funding is expended in a given fiscal year, there are no remaining funds for Native children and their families to access services through this program. Many services from which Native children would benefit, including behavioral health services, are simply not available within PRC

because available funding falls so short of need. In FY 2013, IHS and tribal PRC programs denied approximately $761 million for 146,928 needed contract health services.[viii]

Given the need to maximize the purchasing power of federal government dollars under PRC, the AAP strongly supports the implementation of Medicare-like rates for PRC, including for all physician and other health care professional services and non-hospital-based services. Harmonizing PRC payment with Medicare rates will improve the capacity of the PRC program and improve access to care for children, particularly for specialty care. The U.S. Government Accountability Office (GAO) has determined that the IHS PRC program would have saved $32 million in 2010 just on physician services through the use of Medicare payment methods.[ix] Such a policy must not reduce children's access to needed health services, and therefore we also believe that any such policy must include exceptions that take geography and the availability of specialty care into account.

Conclusion: Thank you again for the opportunity to provide public comment today on the important issue of AI/AN child health needs. Native children need the important health services and public health programs funded through IHS. While there are challenges to improving AI/AN child health, it is clear that there are many successful examples of ways to do so that are cost-effective. Furthermore, strategies and solutions that we devise in caring for AI/AN children will be broadly applicable to problems facing the broad spectrum of American children, whether they live in rural Maine or Nebraska or inner city Dallas or Miami. We thank you again for your ongoing commitment to Native communities, and urge you to provide the funding necessary to meet the health needs of AI/AN children. I would be happy to answer any questions that you may have for me.

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[ii] Centers for Disease Control and Prevention. *American Indian and Alaska Native Populations.* Updated February 3, 2015. Retrieved from http://www.cdc.gov/minorityhealth/populations/REMP/aian.html#Disparities

[iii] Schmitt, S., Schott, L., Pavetti, L., and Matthews, H. *Effective, Evidence-Based Home Visiting Programs in Every State at Risk if Congress Does Not Extend Funding*. Center on Budget and Policy Priorities. February 9, 2015. Retrieved from http://www.cbpp.org/cms/?fa=view&id=4103

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[v] National Indian Health Board. *Special Diabetes Program for Indians (SDPI).* Retrieved from http://www.nihb.org/legislative/sdpi.php

[vi] Department of Health and Human Services. *Fiscal Year 2016 Justification of Estimates for Appropriations Committees- Indian Health Service*. January 2015, 2015. Retrieved from http://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2016CongressionalJustification.pdf

[vii] ibid

[viii] ibid

[ix] U.S. Government Accountability Office. *Indian Health Service: Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services*. Report to Congressional Addressees. April 2013. GAO-13-272.