

Comments of Shaquita Bell, MD, FAAP
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Submitted to the U.S. House of Representatives Committee on Appropriations
Subcommittee on Interior, Environment and Related Agencies

Good Morning Chair McCollum, Ranking Member Joyce, and Subcommittee Members: My name is Dr. Shaquita Bell, and I am here today on behalf of the American Academy of Pediatrics, which represents 67,000 pediatricians around the country. I am the Chair of the AAP Committee on Native American Child Health, a group of leading national experts on this issue. In addition to my role within the AAP, I am a practicing pediatrician at Seattle Children's Hospital, and a Clinical Associate Professor in the University of Washington School of Medicine's Department of Pediatrics. Through my work at the Odessa Brown Children's Clinic, a community health clinic, I work closely with the Seattle Indian Health Board in helping care for their child patient population. I am extremely grateful for the opportunity to testify today on behalf of the AAP to discuss the critical importance of robust federal investment in American Indian and Alaska Native (AI/AN) child health. I thank the committee for its ongoing commitment to funding this work, and to respectfully request increased funding for the Indian Health Service (IHS).

For over 50 years, the AAP has formally conducted work on AI/AN child health. Our commitment to these issues is embodied in the work that we do through a contract with IHS. Each year, our Committee conducts annual site visits to review all aspects of child health services and public health programs at four sites in a different IHS Area. Our experts provide immediate technical assistance to sites to support improved care, working closely with Tribal and IHS facility leadership and child health staff. In addition, we provide guidance to IHS on service units' model programs that the Agency can promote and disseminate, as well as the key challenges they face.

Most recently, I led a team to visit Indian Health Center of Santa Clara Valley in San Jose, with other teams in locations throughout California. While in Santa Clara we met with the amazing team providing excellent care to the patients and families in this region. We learned about a unique and powerful youth program that gave young people job skills and prepared them for their next stages in life. During this and other visits our experts conduct, we also regularly encounter serious challenges, including significant prenatal drug exposure, challenges in accessing needed health services, especially for behavioral health, and difficulty recruiting and retaining talented health providers. When a service unit lacks a pediatric champion, children's needs can quickly lose the priority attention they need. That can lead to a reactive approach; responding to emergencies rather than providing needed preventive care. Wherever we travel across the country, these complexities constitute the story in Native communities; serious challenges, but also inexhaustible and committed people who are making a major difference in the lives of those for whom they care.

Challenges to the Provision of Care to AI/AN Children: We know that Native children face substantial health disparities, many of which are rooted in social determinants of health that stem from the historical trauma Native communities have faced throughout our history. Poverty, alcoholism, substance abuse, chronic illness, child abuse, and other poor health and social conditions are symptoms of these underlying health crises in Native communities, not their cause. In medical terms these are preventable diseases. We know that children thrive when they have safe, stable, and nurturing relationships with adults in their lives. It is essential that public policy support Native

children by providing access to services to meet their health and developmental needs. We must also endeavor to lift children and their families out of poverty to support their lifelong health.

I see the health crises that arise from these social conditions firsthand. I have several patients who are on long wait lists for mental health services. In our community these waits can last up to 4-6 months. Meanwhile many families feel that they are in crisis nearly every day. I have one patient whose anxiety is so bad she hides under the table at school, and cries herself to sleep at night. In caring for Native children, we face these challenges in an environment of extreme resource scarcity and uncertainty. Medical and public health professionals are doing amazing work to improve the health of Native children and their families, but need funding to support that work.

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. However, at current funding levels there is still significant unmet need, and the health disparities Native children face represent a crisis we must address. Even with the increases IHS received for Fiscal Year 2020, the Agency will still fall significantly short of meeting the health needs of its patient population. The AAP urges the Subcommittee to maintain its commitment to AI/AN child health needs in FY 2020 with strong investments in the IHS.

FY 2020 Appropriations: IHS provides essential health services and public health programs serving AI/AN children. Nearly one-third of the AI/AN population is under the age of 18, compared to 24 percent of the total U.S. population. This means that high-quality child health care is foundational to the success of IHS. The AAP appreciates that Congress was able to recently provide IHS with \$6.04 billion for FY 2020, an increase from the \$5.8 billion in FY 2019. While this represents a continuation of increased funding for IHS, we unfortunately know all too well that it still leaves substantial unmet need in the Agency's ability to meet the health needs of those for whom it cares, particularly children. A recent U.S. Government Accountability Office (GAO) report found that in FY 2017, IHS per capita spending was \$4,078. That is significantly lower than per capita spending within the Veterans Health Administration, Medicare, and Medicaid, which were \$10,692, \$13,185, and \$8,109 that same year, respectively.

This significant funding disparity directly impacts children's health. This is especially true for subspecialty care, including mental health, substance use disorder (SUD) treatment, and developmental-behavioral services. Currently, there is a lack of sufficient funding for Purchase/Referred Care services provided away from an IHS or tribal health facility, and the limited funds available often run out before they can provide children access to specialty care. Congress should consider opportunities to support IHS efforts to enroll AI/AN children in Medicaid so that they have access to the Early and Periodic Screening, Diagnostic and Treatment benefit and IHS/Tribal clinics have access to crucial reimbursements. In addition, Congress should significantly increase appropriations for IHS. We urge the Subcommittee to provide the largest possible funding increase for IHS in Fiscal Year 2021 to ameliorate this disparity and support the health needs of Native children.

Advance Appropriations for IHS: AAP supports the provision of advance appropriations for IHS, which would provide the agency with two years of appropriations authority at a time rather than one. This 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. We continue to hear about the challenges in continuing the provision of pediatric health services funded

through IHS during the most recent government shutdown. Funding uncertainty can threaten access to needed pediatric supplies, patients and elders expressing concerns about running out of medication, and personal stress of financial uncertainty for IHS providers.

The AAP would like to thank Chair McCollum for championing the Indian Programs Advanced Appropriations Act (H.R. 1128), and urges Congress to pass this policy into law without delay. Advance appropriations would also enable IHS to better recruit and retain pediatric health care providers through better planning for appropriate hiring. This would increase the proportion of AI/AN children receiving quality care from a dedicated medical home. Public health interventions that generate child health improvements would also benefit from budget continuity and the improved planning it would facilitate. All of this would be possible without additional cost to the federal government, as demonstrated by the successful implementation of this policy at the Veterans Health Administration in 2009. Ultimately, mandatory funding for IHS would provide the greatest stability to live up to U.S. treaty obligations. As an immediate step, advance appropriations would make significant progress in protecting Native children and the professionals who care for them from this instability.

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. I teach and mentor Native students at the University of Washington interested in practicing pediatrics. The burden of student loan debt is a clear and compelling factor in the decisions they make.

We strongly appreciate the value of the Indian Health Service Health Professions Scholarship Program and Health Professions Loan Repayment Program, which are key tools for recruiting and retaining health providers. We appreciate that Congress has continued to prioritize funding for these programs, and increased funding under the Health Professions account by \$7,951,000 in Fiscal Year 2020. Unfortunately, unlike similar programs at the National Health Service Corps, these IHS programs are also taxed. This reduces the impact of loan repayment and scholarships at IHS by over \$9.1 million, diluting the reach of these important Congressional investments. We urge you to continue investing in these crucial programs and to support their tax exemption.

The federal government has done a tremendous job making education available to Native students. To build upon this success, we suggest further efforts to work with educational institutions to ensure that their student bodies accurately reflect the patient populations they serve. Federal funding to educational institutions offers important opportunities to ensure that our medical schools are intentional in building a diverse next generation of health care providers. It is particularly important to improve the training, recruitment, and retention of specialty care providers such as pediatric behavioral specialists, to address significant unmet needs throughout IHS.

Maternal Child Health Coordinator: Given Native children's unique health needs, we are grateful for the Subcommittee's role in ensuring IHS hired a Maternal Child Health Coordinator last year. That position went unfilled for years, leaving a significant aspect of IHS care without the dedicated senior staffing necessary to oversee this critical work. This role is essential in identifying and replicating successes and model programs in maternal-child health programs, and in ensuring the implementation of our recommendations after our pediatric experts conduct site visits for IHS. We would like to thank the Subcommittee for monitoring this process and ensuring that IHS hired a talented professional for this important position.

Parental Substance Use: Across the country, attention to the ongoing opioid crisis has brought into stark relief the significant child health impact of parental SUDs. This is particularly pronounced in Native communities, where we see significant challenges with prenatal exposure to drugs and

alcohol. In addition, we also are seeing large numbers of older children who face the deleterious health effects of the trauma that results from having a parent with an SUD. I care for a toddler whose mother was using heroin and cocaine early in her pregnancy. Thankfully, she was able to access medication-assisted treatment, and continues to do so today. Her son is now one year old and healthy. We spend our well-child visits discussing her wellbeing, which has significant implications for her son's health. While this has made a difference for my patient, many of my patients cannot access MAT and mental health services, and face long wait times to do so. It breaks my heart to hear of parents attempting suicide or losing custody of their children while they wait to access the treatment that could enable them to stay safely together. We urge you to provide IHS needed resources to address the child health impacts of parental SUDs. The AAP-supported Family First Prevention Services Act offers significant opportunities to support this access to treatment, and we urge the Subcommittee to encourage IHS to ensure the coordination of its services with those available through Family First.

ICWA: The AAP is concerned by ongoing attempts to undermine the Indian Child Welfare Act (ICWA), which was enacted in 1978 in response to the longstanding crisis of AI/AN children being removed from their families and communities. ICWA remains a critical federal child welfare law that promotes the maintenance of familial and cultural ties to promote children's health, safety, permanency, and wellbeing. Appropriate ICWA implementation is important for minimizing child trauma and promoting optimal parent-child attachment and facilitation of maintained connection to extended family and culture. The AAP supports effective implementation of ICWA and opposes efforts to undermine this gold standard policy for protecting AI/AN children.

Missing and Murdered Indigenous Women and Girls: Violence against AI/AN women and girls is a public health crisis that inflicts wide-ranging harms on AI/AN children and families. Children and adolescents are uniquely vulnerable to violence, including dating violence, interpersonal violence, trafficking, and other harmful forms of exploitation. Congress should consider opportunities to support IHS engagement in this public health threat to AI/AN women, girls, and communities. Health professionals and health systems have a crucial role to play in the prevention, identification, and treatment of violence against women and children and a collaborative response can best leverage resources from law enforcement, tribes, health professionals, and local communities to protect AI/AN women and girls.

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. We thank you again for your ongoing commitment to Native communities and families like my own 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.