

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 Chair the AAP's 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 federal investment in American Indian and Alaska Native (AI/AN) child health. For 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 the Indian Health Service (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 Cherokee Indian Hospital, in Cherokee, NC. Our visit there found incredible programs, including patient-centered integrated primary care, and an effective family preservation program that keeps children safely with their parents when possible, and promotes kinship care and tribal foster care when it is not. In my work, I have seen countless children enter the foster care system and end up in communities far from their cultural home. This can contribute to the loss of their connection to culture, which in turn contributes to mental health challenges. The program I saw did a tremendous job maintaining those ties, and ensuring children have access to mental health services to prevent fragmentation of care. Seeing a coordinated and culturally specific approach to helping keep children in their home community was inspiring.

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 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. Any of those children may one day take my place in this very seat, and it is my hope that my work can help make that possible. This energy and hope drives the work I do and bring me here today.

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 has recently received, 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.

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 the symptoms of these underlying health crises in Native communities, not the cause of them. In medical terms these are the preventable diseases that we can intervene on. We know that children thrive when they have safe, stable, and nurturing relationships with the 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. As an inpatient attending physician, I had the heartbreaking experience of caring for a 16 year old who overdosed on heroin. As a pediatrician, I never anticipated that my job would require expertise in managing drug overdoses and certainly not that young. In caring for Native children, we face these challenges in an environment of extreme resource scarcity. Medical and public health professionals are doing amazing work to improve the health of Native children and their families. I would like to share with you some stories about my own patients that illustrate the impact of high-quality health services, and the need to provide robust resources to support the work my colleagues and I are able to do.

Success in Serving AI/AN Children: I recently began caring for a young Navajo girl whose adoptive parents are also Native but not Navajo. They have been working with United Indians of All Tribes, as part of an incredible program that provides support for foster and adoptive parents for Native children. The program ensures that the parents have the supports they need to most effectively parent this young girl and help her heal from the trauma she has experienced. The program also provides her with counseling for adjustment challenges commonly associated with the process of adoption from foster care. This program is helping ensure the stability of her adoption and supporting her long-term health and wellbeing.

I also am providing ongoing care for a young Native child suffering from poor weight gain. I saw him numerous times before we were able to work with a gastroenterology team to diagnose him with food allergies. I was able to work with the family to identify a diet that would use traditional foods honoring his cultural heritage and that he could eat safely. This empowered his family to use their cultural practices in a way that promoted their child's health.

Seattle Indian Health Board's work reporting on missing and murdered indigenous women has also helped me start a trafficking work group at Seattle Children's Hospital. This group is examining the intersections of identity among youth we serve to reduce their risk of commercial sexual exploitation. We are particularly focused on supporting youth who identify as both native and transgender or two-spirit, given the data we have about their higher social risks. This work helps us promote positive factors around identity that can promote health and wellbeing.

It's my hope that we can ensure sufficient resources for Native children's health care that all Native children have access to the kinds of programs and services I have seen work so well for my patients. While Native children face unique and significant challenges, we know what works, and just need to make the right investments to support more of it.

I share these stories to demonstrate that despite the many challenges facing the Native children I and my colleagues care for, there are opportunities to support their health and wellbeing and ensure they can thrive. We already know what works, we just need to do more to support it.

FY 2020 Appropriations: The AAP appreciates that Congress was able to recently provide IHS with \$5.8 billion for FY 2019, an increase from the \$5.5 billion in FY 2018. While this represents a continuation of increased funding for IHS, we unfortunately all know 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, and is emblematic of what we as pediatricians caring for Native children see each day: IHS still faces significant funding challenges that limit access to and the quality of critical health services that children need. This is especially true for sub-specialty care, including mental health, substance use disorder (SUD) treatment, and developmental-behavioral services.

While we are aware of the constrained fiscal environment in which you operate, we urge the Subcommittee to provide robust increased funding to IHS to support the health needs of Native children. IHS needs further funding increases to continue providing needed care to this vulnerable population of children. We urge you to provide the strongest possible funding for IHS in FY 2020.

Advance Appropriations for IHS: IHS provides essential health services and public health programs serving AI/AN children. 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. Challenges in continuing the provision of pediatric health services funded through IHS during the most recent government shutdown further underscored the importance of this policy. My pediatrician colleagues working in affected sites shared numerous stories of hardship during the shutdown. They expressed concerns about running out of needed pediatric supplies like neonatal oxygen sensors, and patients and elders expressing concerns about running out of medication. They also shared about the significant personal stress of financial uncertainty, and fears about being about to feed their families and winterize their homes. Advance appropriations is a step toward protecting Native children and the professionals who care for them from this instability.

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.

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 appreciated that Congress has continued to prioritize funding for these programs. 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 approximately \$8 million, diluting the reach of these important Congressional investments. We urge you to fully fund these 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.

Maternal Child Health Coordinator: Given Native children's unique health needs, we are heartened that IHS is currently in the process of hiring a Maternal Child Health Coordinator. That position has gone 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 urge the Subcommittee to continue monitoring this process, and to ensure that IHS is able to expediently hire 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.

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.