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Breaking the Cycle

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Testimony

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Chairwoman Walorski, and distinguished members of the Committee, my name is Dr. Eduardo Ochoa. I am honored to have the opportunity to give this testimony as a representative of Children's HealthWatch, a nonpartisan network of pediatricians, public health researchers, and children's health and policy experts committed to improving children's health in America. I am a general pediatrician and I practice at Arkansas Children's Hospital in Little Rock as a faculty member of the University of Arkansas for Medical Sciences.

Little Rock is one of five sites in the Children's HealthWatch research network, along with Baltimore, Boston, Minneapolis and Philadelphia. Our mission is to improve the health and development of young children by informing policies that address and alleviate economic hardships. We accomplish this mission by interviewing the caregivers of young children on the frontlines of pediatric care, in urban emergency departments and primary care clinics. Since 1998, we have interviewed over 60,000 caregivers and analyzed those interviews to determine the impact of public policies on the health and development of real children.

Justin is one such real child. Hospitalized twice in his first two years of life for poor growth, I saw him in my clinic. He lives in the Mississippi Delta region of Arkansas with his parents and two siblings. The family drove over an hour each way to come to see me. Justin's father works at a sawmill, but his wages fluctuate. When he brings home less money in a month, the family is eligible for the Supplemental Nutrition and Assistance Program (SNAP). But with an uptick in his pay, they lose eligibility for SNAP, and a crucial support for supporting Justin's, and the whole family's, health. The increased pay does not match the value of the SNAP benefit and thus Justin's health can fluctuate with his father's pay and his family's eligibility for SNAP.

Speaking of health, intuitively all of us in this room would probably guess that being hungry or food insecure is not good for a young child like Justin. In fact, there is a wealth of scientific evidence demonstrating the hazard that food insecurity poses to health, across the whole lifespan, starting in pregnancy and early childhood. I want to give you a brief overview of the sorts of harm it can do – being a pediatrician, I have mainly focused here on impacts on children. Adequate prenatal nutrition is critical to ensure normal development of children's bodies and brains and to bolster child food

security. Of particular concern during this period is the greater risk of food-insecure mothers entering pregnancy with insufficient iron stores and with low-folate diets. Poor iron and folic acid status are linked to preterm births and fetal growth retardation, respectively. Prematurity and intrauterine growth retardation are critical indicators of medical and developmental risks that affect not only children's short-term well-being but also extend into adulthood. Children born to mothers who were food-insecure during pregnancy also are at increased risk of birth defects, including cleft palate and spina bifida, among others. Finally, research shows that women who were marginally food insecure and had restricted their eating in an unhealthy way prior to becoming pregnant are more likely to gain excessive weight during pregnancy, which puts the mother at risk for gestational diabetes and obesity postpartum, and can predispose the baby to chronic disease through the phenomenon of prenatal nutritional programming. The first few years of a child's life are marked by the most rapid brain and body growth of a child's entire lifetime – including dramatic changes in cognitive, linguistic, social, and emotional development and in self-regulation, setting the stage for school readiness and adult well-being.

Adequate nutrients are required to support healthy development, but food insecurity can compromise it. The U.S. Department of Agriculture (USDA) estimates that 19.9 percent of all U.S. households with children under 6 years of age experienced food insecurity in 2014, reporting limited or uncertain availability of enough food for an active, healthy life. We know that household food insecurity increases the risk of developmental delays by approximately 70% in early childhood. More specifically, compared to food-secure children, food-insecure children are twice as likely to be in fair or poor health and are 30% more likely to have been hospitalized since birth. Mental health problems such as depression and anxiety disorders in mothers and behavior problems in preschool age children are more common when mothers are food insecure.

But food insecurity does not have to reach the level of outright hunger to cause these problems. Even mild nutritional deficits during critical periods of brain growth among infants and toddlers, also known as marginal food security, may be detrimental, as they are associated with higher odds of child fair or poor health status, hospitalizations, and mothers' depressive symptoms and fair or poor health status, compared with children and mothers in food-secure households.

Food insecurity has also been identified as a serious risk factor for long-term poor health among older children; repeated or persistent exposure to food insecurity

appears to be particularly toxic. For example, food insecurity's impacts on health differ according to age and gender, with younger children experiencing general health impacts, older youth having higher odds of chronic conditions, asthma, and worse mental health, including aggression and thoughts of suicide, and some adverse effects persisting for girls but not boys. Furthermore, food insecurity is linked to developmental consequences for both girls and boys during kindergarten through third grade, and impaired social skills development and reading performance for girls.

What this body of evidence demonstrates clearly is that food insecurity is detrimental on nearly every aspect of physical and mental health. Yet, we have strong solutions to this grave national problem. The furthest reaching of these is the Supplemental Nutrition Assistance Program (SNAP). SNAP is truly a health intervention, helping to protect the health and well-being of those who participate in the program. For example, research has shown that SNAP lowers the risk of household and child food insecurity, reduces the risk of anemia, obesity, and poor health for children and adults, and lowers the risk of hospitalization for failure to thrive & reports of child abuse/neglect. Moreover, it enhances intake of B vitamins, iron and calcium, and improves children's academic performance. It has long-lasting effects too – a longitudinal study found that for those who participated in SNAP in early childhood, SNAP lowered the risk of adult metabolic syndrome and thus also lowered the risk of diabetes and cardiovascular disease and it increased the likelihood that women would be self-sufficient in adulthood.

At Children's HealthWatch, we call SNAP a vaccine, because like a vaccine, it protects children's health now and in the future and also has wider community benefits. Our research on families with young children has shown that SNAP significantly reduces food insecurity for the whole family and importantly, reduces food insecurity among children. Children whose families received SNAP, compared to those who were likely eligible but did not receive it were also significantly less likely to have developmental delays and less likely to be underweight for their age (underweight is an indication of undernutrition). Families as a whole also were better able to make ends meet when they participated in SNAP – those who participated in SNAP were less likely to have had to choose between paying for medical care and paying for other basic needs like food, housing, or utilities.

But like a vaccine, it is essential to be able to apply SNAP in the proper dose and for the necessary course or length of time in order for it to have the maximal impact on

children and families and ensure their long-term success. The Institute of Medicine found that the SNAP benefit is inadequate to purchase a healthy diet and recommended revisiting the base calculation. The dose matters – research we recently released showed that compared to families participating in SNAP when the American Recovery and Reinvestment Act (ARRA) increase to benefits was in place, among our families with young children household and child food insecurity increased significantly when the amount of the SNAP benefit was reduced for all participants in November 2013.

If you will allow me to make another child health connection here, food insecurity and hunger can be likened to a problem like asthma, which needs the right medicine when there's a breathing crisis, and a different, long-term medicine to keep another crisis at bay. It is certainly true that asthma is a big problem in the US-the CDC estimates that 1 in 10 children had asthma in 2009 and everyone in this room probably knows someone with asthma, if they do not have it themselves. But hunger in America is an even bigger problem, and it is not easy to know who is food insecure and who is not. I'll come back to that idea and tell you how we have found a way for health providers to find this out quickly in the clinical setting.

In order to manage asthma properly, so-called rescue medication is essential to deal with the immediate crisis, but this medicine is not enough as a long-term strategy. Children with poorly controlled asthma are at a higher risk of dying from their disease, and children with food insecurity are at higher risk of being in poor health now, which affects them far into their future – potentially changing their level of academic success and subsequent workforce participation. Therefore, food assistance for hungry children and families must be as robust on the long-term side, via systemic programs such as school meals, summer feeding, CACFP, and WIC, in addition to the fundamental cornerstone, SNAP, as on the emergency side, via the emergency food provision networks across America. The systemic programs have the advantages of population-level application, supporting a healthy diet, and in the case of SNAP, a kitchen-table intervention, the ability to purchase and prepare meals in the home. In contrast, the emergency assistance networks, like the rescue medication, have the ability to rapidly respond to immediate needs. America's hungry children clearly need both, in order to address short-term crises and also provide them the longer-term nutritional foundation to give them the chance to develop appropriately, perform better in school, and succeed in the workforce as healthy adults.

As you might imagine, though it exists everywhere in the United States, the severity of food insecurity differs by state and rates can be very high in some states. Where I live in Arkansas, Children's HealthWatch research, based on data from caregivers we surveyed who come into the only pediatric emergency department in the state, shows that nearly one in four (22.7%) families with a child under the age of 4 years in the home is food insecure. This is against a backdrop of 27.7% of Arkansas households with children being food insecure, and having the second-highest overall rate of food insecurity in America. We highlighted these findings in a report titled "Doctor's Orders" released this past spring.

Our report also made note of the fact that food insecurity co-exists with other household insecurities like difficulty paying for utilities and struggling to maintain stable housing, and that families who were food insecure were also more likely to make trade-offs between paying for these basic needs and paying for health care. So you can see that in addition to addressing food insecurity and leading to improved child health, a program like SNAP also leads to a healthier household that is more likely to meet important needs for all its members. As I see all the time in my clinics, low-income parents often face many of these interlocking needs all at once, and if there is a child in the home with a special health care need, the extent to which food, housing and energy needs are addressed in a coordinated fashion puts those families and children in a much healthier place. In fact, research has demonstrated that when eligible families receive support for both food (WIC and SNAP) and housing, they are more likely to be stably housed. If we want children to do well, then we have to care for the whole household. When more households in a community can meet their needs, we have healthier communities.

I mentioned earlier that food insecurity is often not easy to spot or hear, unlike the wheezing that marks an asthma attack. That is why in 2010 Children's HealthWatch did specific research to narrow down the gold-standard 18-item USDA food insecurity screener to a 2-item, validated screening tool that can be used in most clinical settings. We call it the Hunger Vital Sign (HVS) to emphasize that, just like blood pressure or weight which the nurse checks at every medical visit, we need to also be thinking about hunger. With responses to these two questions, any nurse, medical student or doctor could identify a person in household at risk of food insecurity. In fact, last week the American Academy of Pediatrics released the policy statement "Promoting Food Security for All Children", which recommends that the Hunger Vital Sign be used by

pediatricians at scheduled health maintenance visits and other times when indicated. At our institution in Little Rock, pediatric trainees have taken on the pilot project of using the HVS in ‘continuity clinics’, where they see a panel of patients throughout their residency, to identify food insecurity. Thus far, they are finding positive screens at about the rate our emergency department surveys have found, but we will fully analyze the data in the near future.

Using a tool like the HVS will surely get to the level of need our patients have, but then what do we do in response? As our ‘Doctors Orders’ report describes, we have implemented strategies in our hospitals and clinics to try to address food insecurity when we find it. Starting for the youngest patients, we have entered into a partnership with our state health department to place a WIC office inside our hospital. I should note that we modeled this and other ideas on other sites in our Children’s HealthWatch network, specifically Boston Medical Center and Hennepin County Medical Center in Minneapolis. By offering our youngest patients more seamless WIC certification on campus, we hope to address some of the logistical barriers our families have to receiving WIC benefits for which they are eligible. We have also partnered with our state human services department to enable our hospital financial counselors to help families through the SNAP application process as those families apply for Medicaid. Through a partnership with the USDA and again with our state human services department, we are a site for summer and year-round meals in our cafeteria and have fed over 10,000 children thus far on our campus. Lastly, through partnerships with a local food pantry, we also provide emergency food bags to families that have an urgent need for food. I have personally seen the relief on the faces of parents when we are able to send them home with enough food to get them through the next few days.

I mentioned earlier that I practice general pediatrics, and am one of many providers on our faculty. We have a panel of nearly 30,000 Medicaid patients, and intend to build a new primary care clinic within a year, which will be located in an area of Little Rock with a high proportion of Latino and African-American children. As the lead medical director for this clinic, I am helping to design the space and I plan to have financial counselors on staff who can help our families apply for SNAP and Medicaid, utilize community health workers as part of our care teams, and be a location for distribution of meals for children who come to our clinic. We are also exploring ways to incorporate the Hunger Vital Sign into our electronic medical record, as has been done in medical settings across the country.

Real children in real families have real needs that can come up unexpectedly. Gabby was a playful and happy 2 year old in perfectly good health until an illness struck her that caused multiple prolonged seizures that to this day are difficult to control and have caused extreme disability. Gabby's father had a full-time job with a railroad company and was able to weather this situation because Gabby's mom could provide full-time, round-the-clock care to Gabby while he worked. Unfortunately, this was before the Great Recession. When the Recession struck, Gabby's father had his hours reduced, his benefits cut, and ultimately became uninsured. Gabby's health worsened along with his family's crisis. Arkansas had not yet expanded Medicaid under the Affordable Care Act. As we cared for Gabby in our clinic for children with complex medical problems, we were able to help the family apply for SNAP, receive emergency food and other assistance. Remember not just one bad thing happens at a time - slowly, with SNAP and other supports to bridge the gaps that Gabby's family could no longer afford on a lower income, Gabby started to improve. Today Gabby is in better shape, with a combination of medications and an electronic device to control seizures, her parents are both insured, and the family receives supports to help with food, their mortgage payment, and other household necessities. It is essential for families like Gabby's that our systems of support are strong and sufficient. These essential programs, especially SNAP, must be there for families like Gabby's in times of need. SNAP would not have prevented Gabby's particular illness, but it can prevent health complications for children like her and support health and healthy development for many others.

Thank you again, Chairwoman Walorski, for the opportunity to address this Subcommittee today on behalf of Children's HealthWatch and on behalf of the children for whom we all care in our clinics.