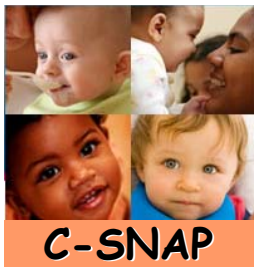

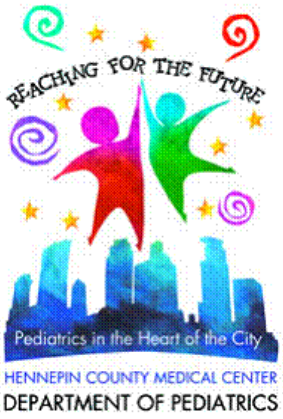

Testimony
Before the Committee on Agriculture
Subcommittee on Department Operations, Oversight, Nutrition, and Forestry
United States House of Representatives

Hearing:
The Short and Long Term Effects of Hunger in America
Wednesday, July 23, 2008

Statement of Dr. Diana Cutts
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Chairman Baca and distinguished members of the Committee, my name is Dr. Diana Cutts. I am honored to be given the opportunity to share with you my experience as a pediatrician and researcher at Hennepin County Medical Center (HCMC) in Minneapolis, Minnesota.

At HCMC my colleagues and I provide care for a diverse, urban population of children, including a significant immigrant population. I work in both out-patient and in-patient settings in a large general teaching hospital, usually supervising a team of bright young medical students, interns, and residents. I have special interest in pediatric nutritional problems and direct an interdisciplinary team of professionals devoted to the care of children who are not growing well. For the past fifteen years, I've also been involved in research on childhood hunger and I am a founder and principal investigator of the Children's Sentinel Nutrition Assessment Program (C-SNAP), a national, multi-site pediatric research program which focuses on the impact of public policies on babies and toddlers under the age of three years.

As I thought about how I could best add to the discussion today, I recognized the tremendous expertise and knowledge of those with whom I sit. And I concluded – with some relief - that I could rely on them to present specific policy information, while I could speak about a large part of what I do – take care of patients and teach trainees. So - I am going to ask you all to join me on rounds as my team this morning, as I see children. Please place your stethoscopes around your necks, but don't bother with white coats – they only scare the kids.

Our first patient is Julia, a 13 month old who is seen following her recent three-day hospitalization for dehydration due to a stomach virus. You tell me her blood chemistries were markedly abnormal at admission, but normalized with IV fluids. Looking at the vital signs that the nurse has obtained, we see that she is regaining though still underweight. In the exam room she begins to scream the minute she sees us, clutching her mother in fear. We examine her over her protests. Mom is told to bring her back for her well child visit in a few months. Her howls cease only as she is carried out of the clinic. Suddenly, the clinic is a lot quieter.

Second on our schedule is Terrance, a 4 year old here to complete forms for enrollment in Headstart. He's a busy pre-schooler, but does not pass the developmental screening today. His mother, 5 months pregnant, is also concerned and accepts our referral to the public schools for more extensive developmental evaluation. Together in the room, we talk with mom and I become concerned about mom's slightly withdrawn and flat affect. She admits yes, she's tired, but she's also a bit depressed. We talk about maternal depression and refer mom to mental health resources. As we come out of the room, we worry about whether mom has the energy to take care of Terrance, the baby, and herself. The smartest among you anticipate that I will want to know if you made sure that the family is enrolled in the WIC program

As they leave for the lab to get his CBC and lead level, one of the CSNAP interviewers approaches me. "Dr. Cutts," she says, "I hope it was okay that I gave that family two bags of groceries." I explain to you that it is our practice to offer a bag of groceries to families who are surveyed for our CSNAP program, which has monitored the rate of household and child food security and other hardships in the clinic for the last 10 years. It turns out you have a background in political science and you ask me more about our findings. So I explain that although Minnesota is known as one of the top-ranking states for most health parameters, the home to a large number of international food corporations with an overall state food insecurity rate of 8.2%, our hospital's rates of household food insecurity for families with children under three are the highest of any of the five CSNAP sites – 35% compared to an average of 15% for the Boston, Baltimore, Little Rock, and Philadelphia sites.

The CSNAP interviewer taps me again. "Dr. Cutts, I'm worried about that mom. She told me that she hasn't had much food for the last week because she was kicked out of her apartment building because the landlord couldn't pay the mortgage, and now she is living with some friends, and her WIC vouchers were lost when they moved, and…" Our morning is unraveling pretty fast – we contact the clinic social worker and try to get a message to mom in the lab to return to clinic so she can meet with him.

I turn to you to teach – Let's talk about the implications of food insecurity for her pregnancy and that not-yet-born child. Prenatal nutrition is essential to a healthy pregnancy, but poor maternal nutrition is associated with greater risk of prematurity, complications of delivery, and low birth weight which increase the likelihood of infant mortality, infant and child health problems, long-term developmental delays, and even chronic disease, such as heart disease and diabetes in adulthood.[i] In addition, maternal depression is more than two and a half times as likely in food insecure households.[ii] Depression impacts parenting in negative ways. We've offered mental health and visiting nurse services, we've ensured that Terrance and she stay enrolled in WIC, which will help protect his health and growth and her well-being[iii], – is there more we should do?

What about Terrance's developmental delay? you ask, interrupting my litany.
I am impressed with your insightful question and will try to remember to give you high marks on your rotation evaluation– I tell you that CSNAP research has shown that very young children who live in food insecure households, even those meeting the level of only mild food insecurity, are two-thirds more likely to be at risk for cognitive, motor or socio-emotional problems on screening tests when compared to those living in food secure households.[iv] Kindergarteners who are food insecure are more likely to have emotional and behavioral problems, too.[v] In older school-age children, we know that food can make a difference in school performance. Some of the strongest words of support for school breakfast programs have come from the school staff who provide time-out supervision for children who are disrupting a classroom. They tell us that a dramatic decrease in these behaviors follows institution of breakfast programs, in addition to improved school attendance and improved standardized test scores.[vi]
At any rate, it's probably not a coincidence that this particular child, whose mother described serious food insecurity, failed our screening. Developmental services to

toddlers and pre-schoolers are the beginning of a societal cost of food insecurity that may be carried on into school years and throughout a lifetime of economic and social difficulties and diminished potential.[vii]

Even I'm getting tired of my long-winded responses to your questions now and the nurse is ready to strangle me. I wisely decide to split you all up to send you each into the rooms of the remaining waiting patients.
And I sit down for a breather.
I think of the earlier patients we saw:

The little screamer, Julia, her family seemed okay, but I know from my own local data that children of color, like Julia, are at highest risk for food insecurity. Poor nutrition is an important contributor to the health disparities that are seen in children of color[viii] and poor children compared to more privileged children. Children from food insecure households are 30% more likely to be hospitalized because of their diminished reserve and vulnerability in the face of typical childhood illnesses.[ix] An average pediatric hospitalization for a child under three costs approximately $11,300[x], so, at least in part, these medical costs are actually another societal economic cost of food insecurity. These kids can't just bounce back because their immune systems are depressed from inadequate nutrition and they often begin a cycle of weight loss and recurrent infections that then perpetuate each other. I'll have to keep a close eye on Julia's growth at the next visit. Could Julia's hospitalization have been avoided if she was living in a more food secure environment? Oh, and was she well-insured? Would hospital bills further erode the family's ability to put nutritious food on the table?

I take a look at the schedule which tells me which patients you are each seeing.

One of you is doing a follow-up for anemia in six month old twins. Young children in food insecure households are two and a half times more likely to have iron-deficiency anemia as children in food secure households.[xi]. And iron deficiency anemia influences young children's brain development in detrimental ways, affecting attention, memory and language and social ability as well as depressing their immune systems. Gotta check in with mom about food security and watch their development carefully as I see them at future visits.

Someone else is interviewing Stephanie, a 14 year old whom I've known since she was 3 years old. She's struggled with childhood obesity since infancy, really, and her last recorded weight was 278 pounds. She began refusing to be weighed 2 years ago, so there's no weight recorded today by the nurse. She's had surgery to remove her tonsils and adenoids because of obstructive sleep apnea, a well-recognized complication of obesity. And she complains of chronic back pain, among other medical complaints. More threatening to her current well-being, her behavior's become out of control – she's sampling every imaginable risky behavior and not attending her alternative school. She's even admitted to suicidal thoughts.[xii] I recall how CSNAP data obtained from this family years ago revealed the most severe food insecurity the interviewer had ever encountered – and our subsequent discussion about the apparent paradox of obesity co-existing with

food insecurity due in great part to tight food budgets forcing parents to choose low-cost foods, which are mostly high in calories and very poor in nutrition.[xiii] Many years later, we still have a long way to go to help people understand this, and to impart the message that a piece of the response to the obesity epidemic must be to address food insecurity.

We end our morning with Brandon, a five year old with a cough, and his grandmother. He tells me a knock-knock joke. You tell me he has a history of asthma and, in fact, was hospitalized three weeks ago for an asthma attack and pneumonia. He was in the hospital for four days, but his grandmother reports he was okay until two days ago, when his cough re-appeared. I'm surprised when she tells me that he's not on any medicines. She explains to me that the family was not able to afford to fill the prescriptions that were given to them at hospital discharge, stating the charge to them was well over $100, and that they needed the money for food, the gas bill, and rent. We work out a plan to provide the needed medications, and hopefully prevent another hospitalization, while still preserving food security, energy access, and housing.

It's time to dismiss you all for your noon conference while I face the chart documentation and a stack of phone messages that I need to get to.

Do all of my patients' ills stem from food insecurity? Of course not. But, my reality is that for more than a third of them, food insecurity is a constant companion to their health, directly and indirectly influencing it in both immediate and distant ways.
None of these children, who each came to clinic for a different reason, had a placard around their neck or a physical sign identifying them as food insecure. They are simply the typical pediatric patients seen all over this country daily in medical clinics serving low-income populations. 29 million children in this country are considered low-income, nearly 40% of our citizens less than 18 years old.[xiv]

These are the faces of child hunger in the United States, very different from the visibly starved Appalachian babies I saw in Life magazine when I was growing up, but no less real, no less impactful. Food insecurity in childhood changes the trajectory of young lives in a real and significant way. The quality of our communities is impacted, and there are high, and rising, economic costs which we all bear.

I feel privileged to play a role in creating a healthy and bright future for the children I see at HCMC. But my reach as their doctor is typically one child, one family at a time. Your reach spans the country and I urge you to think of our time together in clinic and boldly work to create programs and policies that promote healthy and bright futures for all children. For example, I know that Congress is considering another economic stimulus package; I encourage you to make a temporarily increased food stamp benefit part of the package, as it would do so much to directly help the children I've just told you about.

Nutrition assistance programs, such as the Food Stamp Program and WIC, are the medicines needed to treat food insecurity and these accompanying illnesses, but the programs need to be dosed at levels that cure rather than just diminish the problem. The programs are also critical and economically sound investments on the health end of the

equation, as they provide the physiological building blocks necessary for proper growth, health, development, and learning. Better still would be a society in which an adequate, nutritious diet is achievable for every child without targeted intervention programs. Until that day comes, preventive efforts are the best way to avoid the tangible and long-lasting costs of food insecurity in childhood. Other programs that assist low-income families with basic needs that compete with the food budget, such as housing, energy, and childcare assistance, are equally vital, particularly in our current economic climate of rising food and energy prices.

No child deserves to be burdened with the consequences of this fully preventable condition for the duration of his/her life, and no responsible, far-sighted society should permit the widespread incidence of a condition like food insecurity that is guaranteed to produce a less healthy, capable, and productive population.

Class dismissed.
Thank you.

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