United States Congress Hunger Commission

Testimony of Patrick H. Casey, MD

May 19, 2015

Commissioners:

I very much appreciate your allowing me the opportunity and privilege of discussing food insecurity and its consequences in our state, our community, and at our hospital; what we have done at Arkansas Children's Hospital to combat food insecurity; and some ideas for you to consider in your ultimate recommendations to the United States Congress.

First, by way of background, I'd like to describe who I am, and the world in which I work. I'm an academic pediatrician and I have worked at Arkansas Children's Hospital for 36 years. ACH is the only tertiary level children's hospital in Arkansas, and is located in Little Rock, the geographic center of Arkansas. With a few exceptions, all pediatric sub-specialists in Arkansas work at ACH and almost all children in Arkansas who have significant health conditions are evaluated and treated at ACH. Through all my years at ACH I have directed a referral clinic for pre-school children with problems in growth, a condition we call "failure to thrive". Over these years I have been involved in managing literally thousands of children with growth problems due to under nutrition. I'm also a research pediatrician. My research interests are clinical, and have focused on growth problems of pre-school children, pre-term children's growth and development, children with medical complexity, and the social determinants of child health. Since 1998, I have been the Arkansas Principal Investigator of a multi-site group of pediatric

researchers which we call Children's Health Watch. We've collected data during all the intervening years in the emergency departments of our respective hospitals in order to describe the prevalence of food insecurity and other household hardships, such as housing challenges. We assess the consequences of these social determinants on the health and well-being of the children and their households. You can see that I have a relatively unique perspective to describe to you the challenges of food insecurity and its implications for children and their families.

Please allow me to reiterate data you likely have already heard so as to compare Arkansas data to the United States. In the annual survey conducted by the USDA in 2013, 14.3% of all U.S. households (or 17.5 million) reported food insecurity, and 5.6% reported very low food insecurity. In contrast, between 2011 and 2013, the average prevalence of household food insecurity in Arkansas was 21.2% and 8.4% reporting very low food insecurity, the highest prevalence of any state in the United States. About 20% of households with children in the U.S. reported food insecurity in 2013, while nearly 28% of Arkansas household with children reported food insecurity. This involves almost 200,000 Arkansas children. Let me bring this closer to home at Arkansas Children's Hospital. Since 1998, we have interviewed thousands of families with children under the age of four in our emergency department. For most of those years the prevalence of food insecurity documented in these interviews was about 11-12%. However, in 2008, the year of the economic depression, this prevalence doubled up to 22%, and it has not decreased significantly since. In 2013, 23 % of these families in our emergency department reported food insecurity. It goes without saying that households who struggle with

the availability of food likewise also struggle with the cost of housing, energy, gasoline for transportation, and child care.

What about the consequences of food insecurity? Research over the last two decades has documented unequivocally that adults who live in households with food insecurity, independent of all demographic confounders, have worse general physical and mental health, more chronic diseases like hypertension and diabetes, and more obesity in women. Food insecurity during pregnancy has been documented to be associated with certain birth defects and low birth weight infants. Children in food insecure households have poorer general and mental health, and more hospitalizations. But beyond that, such children are more likely to have delayed development during pre-school years, and more academic and behavior problems during school years. Various developmental functions, such as language, short term memory, attention, and locomotor skills are at risk following early under nutrition. And these negative effects are seen not only in the worst degree of food insecurity. Evidence shows that even those who experience marginal food insecurity can suffer important physical and mental health problems.

I'd like to direct you now to the document which we disseminated called "Dr.'s Orders: Promoting Child Development by Increasing Food Security in Arkansas". We developed this document with our colleagues at Children's Health Watch with the advice and input of our local partners at the Arkansas Hunger Relief Alliance, the Arkansas Food Bank, and the Arkansas Department of Human Services. This was released just a few weeks ago. The data and the figures are based on more than 8,000 interviews done between 2004-2014 in the ACH

Emergency Department. If you note in Fig. 1, children in food insecure households are 19% more likely to be hospitalized in our emergency department, 45% more likely to be reported in poor or fair health, and 31% more likely to be reported to have developmental delays. Perhaps even more striking are the household hardships depicted in Fig. 2. For example, households with food insecurity, when compared with food secure households, are four times more likely to be behind on rent and to have foregone health care for their child, and about four times more likely to have energy insecurity and to make health care trade-offs. The data in Fig. 3 are even more striking. Here we focus on households with employed caregivers with education beyond high school. In almost every area the risk is greater than in the full sample. For example, these households are more than 4.5 times more likely to be behind on rent and to forego health care for members of their households. Here's a real life example of a family we met in my clinic. The infant was near 12 months old when he was referred to our clinic due to failure to thrive, a term pediatricians use to describe children who have growth failure due to poor nutrition. He had actually been hospitalized at ACH two times already for this condition. His parents are married, the father has a job, but his work was inconsistent. The father's income was enough to make the household not eligible for SNAP, but not near enough to pay all the household bills. So their child's nutrition suffered.

A few years ago ACH conducted a community needs assessment as mandated by the Affordable Care Act, and food security rose to near the top of the identified needs in Arkansas. That finding, along with the strikingly high prevalence of food insecurity that we've identified in our interviews, spurred the hospital into action. We convened a group, including folks from the Arkansas Hunger Relief Alliance, Arkansas Food Bank, Arkansas Health Department, the

Arkansas Department of Human Services and the former Governor's office, along with the administrative leaders at ACH, and we began to generate ideas and take action. I'd like to describe for you a few of these actions, some of which are described in our document which you have. Perhaps the program that received the most publicity is the free lunch program in which we offer free lunch to any child seen on our campus. With the assistance and leadership of the Arkansas Department of Human Services, the Governor's office, and the Regional USDA office we implemented the summer food program in the summers of 2013 and 2014. But we have been able to continue that into the fall and winter and through the remainder of the year in the program the USDA is now calling the Children's Medical Feeding and Nutrition Program. We have provided nearly 30,000 free lunches since this summer, and we understand that the USDA is now attempting to introduce this in other hospitals. In a separate effort, our financial counsellors were trained in the process of taking SNAP applications, and over the years we have facilitated about 400 such applications. Under the leadership of the Arkansas State Health Department, a few months ago we opened a WIC office on our campus one day per week, and we hope that this will expand to full time in the near future. We have teamed up with a food pantry located down the street from the hospital, and we offer bags of food when urgent needs are identified. We are working with that pantry to devise a traveling food pantry in a renovated school bus, and we will be starting a community garden with them this spring located on their grounds. We have provided five courses of Cooking Matters, developed by Share our Strength, and we routinely provide grocery store tours in Cooking Matters at the Store. I've been extremely appreciative how willingly and aggressively ACH administrative leadership has stepped into the battle against food insecurity.

What recommendations would I make to the commission to reduce food insecurity? I would begin by suggesting that hospitals that care for children should consider some variation of what we have done here. They would need to develop partnerships and alliances with leaders of local anti-hunger organizations, food banks and food pantries, and local or state level health or human service departments, in order to develop steps that will work for them locally. In some cases, greater flexibility from federal and state agencies which administer programs would facilitate their delivery at hospitals. But none of these steps will fix the problem of hunger. The solution lies in policy action. From the big picture, we need to find ways to better educate and train adults for positions that pay adequately. In a state like ours, it is unlikely that a poorly educated, poorly trained parent can go out and find a job with adequate income to fully support their family. It is naïve to think otherwise. As for those who work for minimum wage, we need to assure adequate SNAP benefit levels so that the low wage does not severely diminish their eligibility or benefits from SNAP. I would urge that Congress maintain and even expand SNAP and WIC eligibility and benefits, along with school breakfast and lunch. Research by us at Children's HealthWatch, and by others, has demonstrated the benefits of SNAP and WIC on the health and developmental/academic well-being of children. We have come to think of these programs as prescriptions for healthier children. We need research on the adequacy of SNAP benefits in varying family contexts, which relate to SNAP benefit levels. I'll remind you of the family I described earlier; the father's income made them ineligible for SNAP, thus resulting in household hunger. Cutting these food assistance programs, as is being considered by Congress, will result in the loss of too many meals for too many children every month. The loss of food to children if they cut these programs is real. I see this in the faces and the bodies of the

children that I treat. The cost of these nutrition programs would likely be offset by the savings that would result from other federal expenditures, including health and education. I would also encourage that Congress consider eliminating various barriers that families face in applying for federal assistance. Too often I hear from families that they have difficulty getting to the WIC office when it's open. At our hospital, our counsellors have to take two applications, one from Medicaid and the other for SNAP; combining these would be of great help to our families. One last thought, and one of particular relevance in Arkansas. Any program that increases household income should be given priority. The Earned Income Tax Credit essentially subsidizes low wage workers' income by reducing the amount of taxes that low income families owe. Unfortunately, Arkansas does not take advantage of this important anti-poverty social policy. Would it be possible for Congress to do more to encourage states to take advantage of the EITC?

I appreciate your giving me the opportunity to speak with you this morning. Clearly my experiences as a pediatrician caring for under-nourished children over 35 years has driven my perspective on these issues. I find it unimaginable that our country's leaders would seek to fix our economic financial woes by damaging the futures of our children. A child cannot be healthy and learn if they are hungry. When our children go hungry, we will all pay the price in terms of lost potential, for our schools, our communities, and our country. Thanks once again.