Testimony Before the Committee on Health
Council of the District of Columbia

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Good morning, and thank you for this opportunity. I am Jeff Hild, the Policy Director at the Redstone Global Center for Prevention and Wellness at the George Washington University School of Public Health.

I’d like to speak today about three bills under consideration: The “Adverse Childhood Experiences Task Force Act,” the “Community Health Investment Act” and the “Women, Infants, and Children Program Expansion Act.”

Community Health Investment Act
We support the Community Health Investment Act and urge the Council to further strengthen it prior to passage.

Although the community benefit standard for tax exempt hospitals has been in place nationally since 1969, community benefit spending has tended to focus on work done inside the hospital, including uncompensated care and education, and rather than work in the community. Changes made by the Affordable Care Act, an evolving understanding of what impacts health, and a growing interest on the part of hospitals to expand their missions beyond the hospital into the community, makes this an ideal time for the District to consider ways to further enhance community benefit spending.

Health is greatly influenced by the “social determinants,” including access to healthy food, good jobs, affordable housing in safe neighborhoods, and opportunities for play and physical activity. The physical environments and social conditions in which people live, learn, work, pray and play have significant impacts on a person’s health.

Hospitals play a critical role in addressing social determinants of health by providing care, and through their status as employers, purchasers, and investors. Some hospital and health care systems have become anchor institutions within their communities with a focus on addressing the underlying conditions that lead to poor health outcomes. For example, University Hospital in Cleveland, Ohio has supported a hydroponic vegetable farm, a laundry, and a business-to-business supply company
for the hospital, all in the community surrounding the hospital. These efforts increased local employment, enhanced the tax base, and provided stability for the community. While not all of these efforts count as community benefit spending by the IRS, many fall within the categories of community health improvement services or community building activities.

The Affordable Care Act amended the Internal Revenue Code related to the community benefit obligations of tax-exempt hospitals, including a new requirement that tax-exempt hospitals conduct periodic community health needs assessments and link those assessments to implementation strategies to address high priority areas. Many of the assessments in DC have identified chronic conditions such as obesity and diabetes as conditions affecting our community, and these diseases can be linked to social determinants, such as lack of physical activity, access to healthy foods, or neighborhood safety.

The stage is clearly set for hospital community benefit spending to focus on community health improvement and the social determinants of health. It is timely that this legislation would expressly add and define “community benefits” alongside charity care, and require health care facilities to include community benefits as a condition for obtaining and maintaining a certificate of need. These changes reflect the national trends toward increased hospital engagement in community health outcomes and could direct additional investments in the District toward initiatives that can help reduce our health disparities and support the wellbeing of whole communities, not just individual patients.

As you continue work on this legislation, please consider the following changes:

1. In the new “Community Benefits” definition, revise health improvement to community health improvement. This modification will help ensure that the DC code reflects the broader concept of community benefit.
2. Consider mirroring the IRS definitions, which also include “community building” as a category distinct from “community benefit.” The IRS recognizes a separate category of spending called “community building.” Community building is defined as activities that promote the health and wellbeing of communities as a whole, beyond individual care or patient supports, such as housing supports, job training, and early childhood education.

WIC Program Expansion Act
The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) serves over 13,000 District families and is proven to improve nutrition, health, and other outcomes for low-income families. Increased participation in WIC, as the WIC Program Expansion Act seeks to do, would make the District a healthier and more equitable city. We fully support Council moving forward with this legislation.
Forty years of research have produced strong evidence that WIC is effective. Among other findings, the research has found that:

- Immunization rates in children participating in WIC are comparable to affluent children and WIC participants are more likely to receive preventive health care than other children;
- Women who participate in WIC during pregnancy give birth to healthier babies with lower rates of infant mortality (especially among African Americans);
- Children of mothers who were WIC participants during pregnancy were more likely to meet developmental milestones;
- WIC participants buy and eat more fruits, vegetables and whole grains.
- WIC promotes breastfeeding, through counseling, peer support, enhanced benefits, and better infant feeding practices, particularly after changes to the WIC package that were finalized in 2009.

WIC is effective, in large part, because it starts early—supporting pregnant mothers and the youngest children. We know that healthy nutrition during pregnancy can have a significant impact on birth outcomes. We also know that adversity during early childhood affects healthy development and can have lifelong impacts on health. WIC intervenes early to support access to healthy foods for low-income families and to deliver nutrition education, decreasing socioeconomic disparities in nutrition among young children.

WIC is also an important tool in combating childhood obesity, through promotion of breastfeeding and healthy nutrition, but also through screening and engagement with caregivers. While more research is needed, obesity rates declined among WIC children in 31 states after the WIC package was changed to provide lower fat dairy and smaller servings of juice. It is also important to note that WIC has additional benefits for the community. Because WIC authorized stores must carry a variety of healthy foods, healthier options become available to the whole community. Although I am not aware of any DC-specific studies, research in other cities and states has found significant increases in the availability of healthy foods in small grocery stores and corner stores since the updated WIC food package was implemented.

The WIC Program Expansion Act could extend the positive impact of WIC in several important ways. First, by identifying barriers for small stores to become authorized WIC vendors and implementing outreach strategies to overcome those barriers, more small retailers, particularly in areas of the District with few large grocery stores, may begin to carry healthier food options. Second, the legislation would require increased coordination between various District agencies to target outreach to SNAP and Medicaid beneficiaries who are not WIC participants. This coordinated effort will likely result in increased enrollment in WIC among families who are already income eligible. Finally, the legislation would task the Department of Health
with convening a WIC Outreach Advisory Board to identify strategies to increase WIC participation and participant experience.

While we support the current version of this legislation, we urge you to consider the following changes:

1. Require a report on WIC funding and expenditures as well as the plan for assisting small stores to become authorized vendors. Both of these pieces are important and should be included.
2. Include at least one WIC participant on the WIC Outreach Advisory Board.

Finally, while perhaps outside the scope of this hearing, Council should strongly consider what additional resources the Department of Health will need to fully carry out these new provisions and make the needed allocations during the next budget cycle.

ACEs Task Force Act
We are supportive of the creation of the Adverse Childhood Experiences Task Force and hope that it can be used as a catalyst to take action to make our city more equitable and resilient.

The earliest years of a child’s life are a time of incredible growth, brain development, and learning and have a profound and lasting effect on health and well-being. Exposure to traumatic, negative events and stressors – referred to as Adverse Childhood Experiences (ACEs) – are directly linked to achievement of developmental milestones during childhood and the early onset of chronic disease, such as obesity and diabetes. Childhood adversity is also linked to negative behavior outcomes across the lifespan including substance abuse, risky sexual behavior and low educational and economic attainment. ACEs include traumatic events such as abuse or witnessing violence as well as family disruption, including maternal depression, parental incarceration or addiction. Food insecurity or unstable housing also cause harm and may disrupt a child’s healthy physical and neurological development.

Research from the Centers for Disease Control (CDC) has found that individuals exposed to 4 or more ACEs were 1.6 times more likely to develop diabetes and were up to 12 times more likely to suffer from depression or substance abuse compared to those with no ACEs.

Nearly one in four District children have experienced 2 or more ACEs, and it’s likely that children living in areas of concentrated poverty or violence are exposed to even more. Fortunately, traumatic experiences can be prevented and children can be buffered, enabling them – and their families – to build resilience against the impacts of ACEs through quality early childhood education, enhanced community and family supports, and early intervention to address stressors in a child’s life.
Part of our work at the Redstone Center, includes a project called Building Community Resilience (BCR). BCR does work in five regions across the country, including in DC, to address what we call the “Pair of ACEs”—Adverse Childhood Experiences within the context of Adversity Community Environments. We use the [graphic of a tree](#) to illustrate the idea that the leaves on the tree (childhood experiences) will only be as healthy as the soil (the community environment) that the tree is rooted in. The idea is that ACEs do not occur in a vacuum, but are the product of failed or uncoordinated systems. While it is critical to ensure that child serving organizations, such as pediatric practices, understand ACEs and are trauma-informed, it is also important that other systems such as criminal justice, housing, education, land-use planning, job-training and others are part of the effort to build resilient communities that can bounce forward from adversity.

Part of our work in the District has been partnering with the Office of Urban Resilience (OUR) in the Executive Office of the Mayor, to conduct focus groups with various community stakeholders to identify causes of adversity and potential solutions. The OUR is part of the 100 Resilient Cities Initiative, supported by the Rockefeller Foundation. OUR will be putting out a resilience strategy for the District later this year that will focus on both environmental shocks, such as floods, as well as everyday community adversity, such as housing affordability, displacement, and community violence. This Office should certainly be represented on the Task Force and Council should consider whether OUR can fulfill the goals set out in the legislation or will be better suited as a participant in the task force.

In addition to the participation of the Office of Urban Resilience, we also suggest that both the housing and law enforcement sectors be members of the task force. Safe, stable and affordable housing is a critical support for families, and displacement contribute to adversity amongst District families. We have seen from our work in the District that violence, police-community interactions, and incarceration are also significant sources of adversity. The task force should include voices that can speak to these issues. Finally, the task force should include community members or some type of community representative.

In Section 2 of the legislation, in addition to identifying policy initiatives and budgetary priorities, we recommend inclusion of language that calls for identifying a permanent structure to coordinate various agencies’ responses to ACEs and community trauma. Several models that have been employed elsewhere including Children’s Cabinets in various states or Trauma-Informed Offices that help train government agencies and ensure needed collaboration across all branches of government. Also in Section 2, we recommend that the Task Force expressly examine the training needs of various child-serving agencies within the District to become more trauma and ACEs aware.

Thank you for the opportunity to testify in support of these three important pieces of legislation.