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Health, and Finance and Revenue, Council of the
District of Columbia. Hearing on: B22-203 "Infant
and Toddler Developmental Health Services Act of
2017" and B22-355 "Bolstering Early Growth and
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**Testimony Before the Committees on Education, Health, and
Finance and Revenue
Council of the District of Columbia
Hearing on: B22-203 “Infant and Toddler Developmental Health Services Act
of 2017” and B22-355 “Bolstering Early Growth and Investment Act of 2017”**

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The George Washington University**

September 27, 2017

Good morning, and thank you for this opportunity. I am Jeff Hild, the Policy Director at the Sumner M. Redstone Global Center for Prevention and Wellness at the George Washington University School of Public Health. Prior to coming to the Redstone Center, I was the Chief of Staff at the Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services, which is the primary federal agency administering the Head Start and Child Care and Development Block Grant programs and parts of the Maternal, Infant, and Early Childhood Home Visiting program.

I'd like to speak today about both the “Infant and Toddler Developmental Health Services Act” and the “Bolstering Early Growth and Investment Act.” Both pieces of legislation, if enacted and fully funded, could help create a more equitable system of early childhood care in the District and lead to improved health outcomes and increased school readiness for all District children, particularly those living in neighborhoods where disparities are most pronounced.

The earliest years of a child's life is 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 as well as health outcomes later in life, such as obesity and other chronic diseases. 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 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 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.

Several provisions in the Infant and Toddler Developmental Health Services Act would bolster the resiliency and health of children, their families and communities in the District.

A Healthy Steps Pediatric Primary Care demonstration program would allow more pediatric practices to implement this evidenced-based model. By integrating child development specialists and community health workers into clinical practice, building referral networks with community service providers, and coordinating with programs like Head Start, Strong Start, and home visiting, the Healthy Steps model can help to address the myriad of factors that impact a child's health but cannot be treated in a medical clinic. For example, a pediatrician may see a child with asthma and know it is caused by unsafe housing but may not have the tools to help the family fix it. Under the Healthy Steps model, the pediatric practice could have a community health worker visit the home, connect the family with a housing provider or legal services provider to help remedy the underlying cause of the health condition. In addition, the legislation's emphasis on co-locating lactation supports and WIC sites with pediatric practices using the Healthy Steps model could decrease food insecurity for families with young children and improve the health outcomes of both parents and children, including rates of obesity and diabetes. The legislation would begin to establish an integrated system of supports – a valuable investment in our youngest residents.

I would recommend adding into the application requirements for pediatric practices, plans to screen for ACEs and trauma and how they would incorporate those findings into their services. In addition, the reporting and evaluation should include specific health behaviors and outcomes for the children served, including achievement of developmental milestones and linkages to community programs.

Expansion of the District's Healthy Futures program to provide mental health consultation in all subsidized child care facilities would provide much needed mental health services to more District children. Importantly, it would also bring supports to Early Childhood Development (ECD) teachers to manage conflict, reduce expulsions, and promote healthy social-emotional development. The initial evaluation of the Healthy Futures program found several notable outcomes, including expulsion rates that are half the national average, an increase in positive child-teacher interactions, and decreased job stress for ECD teachers. These findings are consistent with other national studies commissioned by the Federal Office of Child Care. It's worth noting that one aspect we know less about is the impact on

families. In addition, ways to connect the in-center services with community support services for parents should be explored.

Finally, the identification of potential sites for new child development centers in Wards 7 and 8 could help ease the acute shortage of child care options in the East End and the District as a whole. In 2015, there were just 7,600 licensed child care slots for more than 26,000 infants and toddlers under 3 years old, and Wards 7 and 8 have the highest proportion of children under 4 years old in the District. There is also an opportunity to think strategically about placement of new centers in areas with existing opportunities for co-location of other services. Including new child development centers should be part of establishing a robust system of health in the East End, which could be anchored by a new hospital at the St. Elizabeth's site, serving as a "health hub." Including child care as part of a new health hub would make for increased integration and coordination of the range of health and community services that we know are needed to prevent and buffer against ACEs and improve outcomes for children, families, and their communities.

The other bill under discussion today-- the Bolstering Early Growth Investment Amendment Act--takes important steps toward increasing the supply of quality child care, supporting providers, and adequately compensating ECD teachers. The provision to bring subsidy rates in-line with actual costs and the goal of pay parity between ECD and K-12 teachers could contribute to increased quality and address some of the concerns related to retention that have arisen since the new education standards for ECD teachers were adopted. In order to ensure that the changes lead to increased quality, I'd recommend that legislation expressly link enhanced supports to increased quality and have the compensation task force examine how compensation changes could positively impact program quality. I would further recommend that affordability and access be directly examined so that the District can have a clearer picture of how changes in both subsidy rates and compensation could positively impact affordability and access for families. Finally, in the facilities section of the legislation, I would recommend the committee consider adding provisions to the priority area designation that focus both on areas with the highest need as well as location that could be co-located with other services or otherwise leveraged to enhance services delivered to children and families or provide additional benefits to the community.

All of the laudable initiatives in both bills will need to be funded. While the District, thanks to the leadership of members of these committees, is in a strong fiscal position, new sources of dedicated revenue may be needed. One policy option that the council should consider is an excise tax on sugar sweetened beverages. Such a policy has the double benefit of decreasing consumption of added sugar (and research shows that sugar sweetened beverages contribute nearly 40% of the added sugar in our diets, contributing greatly to the obesity and diabetes epidemics in the District and elsewhere) and providing a mechanism for funding programs that make our children and communities healthier. Philadelphia is an instructive example. The City dedicates the vast majority of funding from their tax on sugar sweetened

beverages to early childhood education. In the first six months, \$39 million has been raised. The City estimates adding 6,500 new pre-K slots over the next five years. Moving forward, the Council should consider a similar policy solution, tailored to the unique needs of the District.

In summary, the opportunities provided by B22-203 and B22-355 to enhance health and education supports for the District's youngest children, build on existing models that work, and increase coordination of service deliver can reduce the impacts of Adverse Childhood Experiences, make our communities more resilient and our children, families and communities healthier.

Thank you for this opportunity.