TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred House Bill No. 762 entitled "An act relating to the Adverse Childhood Experience Questionnaire" respectfully reports that it has considered the same and recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS AND PURPOSE

(a) It is the belief of the General Assembly that controlling health care costs requires consideration of population health, particularly Adverse Childhood Experiences (ACEs).

(b) The ACE Questionnaire contains ten categories of questions for adults pertaining to abuse, neglect, and family dysfunction during childhood. It is used to measure an adult's exposure to traumatic stressors in childhood. Based on a respondent's answers to the Questionnaire, an ACE Score is calculated, which is the total number of ACE categories reported as experienced by a respondent.

(c) In a 1998 article entitled "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults" published in the American Journal of Preventive Medicine, evidence was cited of a "strong graded relationship between the breadth of exposure to abuse or

household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults."

(d) The greater the number of ACEs experienced by a respondent, the greater the risk for the following health conditions and behaviors: alcoholism and alcohol abuse, chronic obstructive pulmonary disease, depression, obesity, illicit drug use, ischemic heart disease, liver disease, intimate partner violence, multiple sexual partners, sexually transmitted diseases, smoking, suicide attempts, and unintended pregnancies.

(e) ACEs are implicated in the ten leading causes of death in the United States.

(f) An individual with an ACE score of two is twice as likely to be at risk of rheumatic disease. An individual with an ACE score of four has a three to four times higher risk of depression; is five times more likely to become an alcoholic; is eight times more likely to experience sexual assault; and is up to ten times more likely to attempt suicide. An individual with an ACE score of six or higher is 2.6 times more likely to experience chronic obstructive pulmonary disease; is three times more likely to experience lung cancer; and is 46 times more likely to abuse intravenous drugs. An individual with an ACE score of seven or higher is 31 times more likely to attempt suicide.

(g) Physical, psychological, and emotional trauma during childhood may result in damage to multiple brain structures and functions and may even alter a child's genes.

(h) ACEs are common in Vermont. In 2011, the Vermont Department of Health reported that 58 percent of Vermont adults experienced at least one adverse event during their childhood, and that 14 percent of Vermont adults have experienced four or more adverse events during their childhood. Seventeen percent of Vermont women have four or more ACEs.

(i) The impact of ACEs is felt across all socioeconomic boundaries.

(j) The earlier in life an intervention occurs for an individual with ACEs, the more likely that intervention is to be successful.

(k) ACEs can be prevented where a multigenerational approach is employed to interrupt the cycle of ACEs within a family, including both prevention and treatment throughout an individual's lifespan.

(l) It is the belief of the General Assembly that people who have experienced adverse childhood experiences can be resilient and can succeed in leading happy, healthy lives.

Sec. 2. TRAUMA-INFORMED CARE IN THE BLUEPRINT FOR HEALTH

(a) Using existing appropriations if available, the Director of the Blueprint for Health, in consultation with appropriate stakeholders who are interested participants, shall explore ways to implement the following initiatives:

(1) use of an appropriate and voluntary screening tool containing questions on the ten categories of adverse childhood experiences at Blueprint for Health practices, including consideration of patient privacy, appropriate training for providers using the screening tool, and increased per member, per month payments to incentivize use of the screening tool; and

(2) a pilot program in at least two counties using the Vermont Center for Children, Youth, and Families' Vermont Family Based Approach, in which participating community health teams may hire a family wellness coach, or contract with an appropriate community partner organization who shall serve as a family wellness coach, to provide prevention, intervention, outreach, and wellness services to families within the community health team's region.

(b) On or before December 15, 2014, the Director of the Blueprint for Health shall submit a report to the House Committee on Health Care and to the Senate Committee on Health and Welfare containing findings and recommendations regarding the implementation of the initiatives listed in subsection (a) of this section, including funding constraints and opportunities.

Sec. 3. VERMONT FAMILY BASED APPROACH PILOT PROGRAM

(a) Using existing appropriations if available, the Commissioner of Health, in consultation with appropriate stakeholders, shall develop and implement a pilot program for primary schools in at least two counties throughout the State

using the Vermont Center for Children, Youth, and Families' Vermont Family Based Approach.

(b) A nurse or mental health professional employed at a primary school within in a participating county may apply to the Department of Health to take part in a four-day training program on the Vermont Center for Children, Youth, and Families' Vermont Family Based Approach. The Department shall select nurses or mental health professionals from among the applicants to participate in the training at the Department's expense.

(c) Upon completion of the four-day training program, each participating nurse or mental health professional shall employ the training received on the Vermont Family Based Approach in his or her school district. This shall include a formal presentation on the Vermont Family Based Approach for faculty members at the participating nurse or mental health professional's school district.

(d) On or before January 15 of each year through January 15, 2020, the Department shall report to the House Committee on Health Care and to the Senate Committee on Health and Welfare regarding any findings or recommendations related to the Vermont Family Based Approach Pilot Program in schools.

(e) The Vermont Family Based Approach Pilot Program shall cease to exist on June 30, 2020.

Sec. 4. 18 V.S.A. chapter 13, subchapter 3 is added to read:

Subchapter 3. Trauma-Informed Care

§ 751. DIRECTOR OF ADVERSE CHILDHOOD EXPERIENCE, EDUCATION, AND TREATMENT

The Commissioner of Health shall designate a director of Adverse Childhood Experience, Treatment, and Prevention within the Department who shall be responsible for:

(1) surveying existing resources in each community health team's region and identifying gaps in resources, if any;

(2) coordinating the implementation of long-term services throughout the Department for persons who experienced trauma a child;

(3) providing advice and recommendations to the Commissioner on the expansion of long-term services throughout the State for persons who experienced trauma a child; and

(4) developing and implementing programs, if applicable, aimed at preventing and treating adverse childhood experiences.

Sec. 5. RECOMMENDATION; UNIVERSITY OF VERMONT'S COLLEGE OF MEDICINE AND SCHOOL OF NURSING CURRICULUM

The General Assembly recommends to the University of Vermont's College of Medicine and School of Nursing that they consider adding or expanding

information about the Adverse Childhood Experience Study and the impact of adverse childhood experiences on lifelong health to their curricula.

Sec. 6. TRAUMA-INFORMED EDUCATIONAL MATERIALS

(a) On or before January 1, 2015, the Vermont Board of Medical Practice, in collaboration with the Vermont Medical Society Education and Research Foundation, shall develop educational materials pertaining to the Adverse Childhood Experience Study, including available resources and evidence-based interventions for physicians, physician assistants, and advance practice registered nurses.

(b) On or before July 1, 2016, the Vermont Board of Medical Practice and the Office of Professional Regulation shall disseminate the materials prepared pursuant to subsection (a) of this section to all physicians licensed pursuant to 26 V.S.A. chapters 23, 33, and 81, physician assistants licensed pursuant to 26 V.S.A. chapter 31, and advance practice registered nurses licensed pursuant to 26 V.S.A. chapter 28, subchapter 3.

Sec. 7. DEPARTMENT OF HEALTH REPORT

(a) On or before November 1, 2014, the Department of Health shall submit a written report to the Green Mountain Care Board containing:

(1) recommendations for incorporating education, treatment, and prevention of adverse childhood experiences into Vermont's medical practices and the Department of Health's programs;

(2) recommendations on age appropriate screening tools and evidence-based interventions for individuals from prenatal to adult; and

(3) recommendations on additional security protections that may be used for information related to a patient's adverse childhood experiences.

(b) The Green Mountain Care Board shall review the report submitted pursuant to section (a) of this section and attach comments to the report regarding the report's implications on population health and health care costs. The Board shall submit the report with its comments to the Senate Committee on Health and Welfare and to the House Committee on Health Care on or before January 1, 2015.

Sec. 8. EFFECTIVE DATE

This act shall take effect on July 1, 2014.

(Committee vote: _____)

_____

Representative [surname]

FOR THE COMMITTEE