Testimony to Senate Health and Welfare
January 11, 2018

AHS S 261: An act relating to mitigating trauma and toxic stress during childhood by strengthening child and family resilience

Introductions:

- Paul Dragon, Director of Policy and Planning, Agency of Human Services
- Kathy Hentcy, Director Mental Health, Health Care Integration
- Dr. Breena Holmes, Director of Maternal and Child Health

Overview

Thank you for your work on this Bill and for the work over the past year particularly in the thoughtful work embodied in the Adverse Childhood Experiences Working Group. We support many of the ideas in this proposal and have suggestions for other components of the proposal. I would like to briefly go through each section giving the overall AHS perspective and then have Kathy and Dr. Holmes provide more context and substance in terms of our work.

Section 1 - Findings:

S 261 cites findings in which we agree, and which have guided our progress at the Agency particularly over the past two years. Our recently renewed and approved AHS policy on trauma and resiliency cites much of the same research. We think the attention you give in the findings to the opioid epidemic is an important nexus that we will would like to continue to advance and focus on. Our forum to do this is the Opioid Coordinating Council which AHS co-facilitates.
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Section 2 - Purpose:

We agree with the purpose. To be successful AHS and others will have to take a comprehensive and integrated approach to trauma and resiliency, and this includes strong linkages to the medical community. This purpose is consistent with the AHS public health approach outlined in our Act 43 report and is consistent with our vision of the role of the Trauma Informed Services Director. Both Kathy and Dr. Holmes will be discussing our approach in more detail.

Section 3 – Definitions:

Your definitions are the same as those in our AHS policy including the definition for a trauma informed organization. Becoming a trauma informed organization is a priority. Kathy will be talking more about training which is foundational to becoming a trauma informed organization and our partnership with the Child and Family Trauma Workgroup. This workgroup has helped us revise and update our AHS Trauma Informed System Policy (Handout).

Section 4 – Coordination of Trauma-Informed Systems

We believe that a coordinator of trauma informed systems will help advance our work to become a trauma informed organization. However, we do not have the funding for a position or the capacity to transition another staff person into this position. The coordination currently has been through the efforts of a small group of people along with technical assistance from the Child and Family Trauma Workgroup.

We think our focus should be on "strengthening existing programs" rather than "establishing new programs." As noted in our Act 43 report (Handout) we completed an inventory of all AHS grants and programs. There are approximately 750 grants and 282 programs. Of the 282 programs 87 programs support three or more Strengthening Family Protective Factors. These programs demonstrate a strong fidelity to principles and practices that build resilience. We think it is important to strengthen these existing programs by making our organizations and delivery systems more trauma informed. This includes the continuum of services from prevention to customer service, eligibility, intervention, case and care management, referrals and follow up.

Section 5 – Childhood Trauma Tri-Branch Commission

We prefer not to establish and administer another Commission. We don't have the capacity to serve another commission (administrative, legal, technical). We currently administer over a dozen boards and commissions and participate on many dozens of boards, commissions and councils. We would prefer to continue to work through our Child and Family Trauma Workgroup to develop a practical workplan that builds on what we already know, what can be improved and what can be brought to scale. If there is to be a Coordinator we would not want this person's time obligated toward the Commission but focused on working with AHS and the Child and Family Trauma workgroup to continue to move AHS and its partners in the direction of a trauma informed organization.

Section 6 Trauma Prevention and Resiliency Building Trainings

With additional capacity we can update and make current the website for trauma training and information and encourage stakeholders to review the website. We do not think there is a need for another report. We would rather use the Act 43 report and then present updates on our work as needed.

Section 7 Expansion of Pediatric Primary Care and Home Visiting Partnerships

The legislation asks that DCF link primary care with home visiting in all counties with each county having a partnership by 2023. We are supportive of home visiting and have three existing evidence based, home visiting models along with several other home visiting programs throughout the Agency. Dr. Holmes will talk more about this. We would want to know more about how this proposal links and maximizes our current home visiting programs.

Section 8: Parent – Child Center Evaluation

This asks that before January 1, 2019 that DVHA evaluate and report on which services offered through the parent child center network are eligible for match for Medicaid funds. To my knowledge much of this work has been done by DVHA for parent child centers participating in the Children's Integrated Services program. PCCs are billing to a "bundled" code for a range of services. In addition, an expansion of billing would have a budget impact and an impact on capacity and resources for the evaluation and report. We would want to further understand the intent here.

Section 9: Bright Futures Guidelines

Dr. Holmes will be elaborating on this connection.

Section 10: Blueprint for Health Strategic Plan

This section asks that providers assess trauma and toxic stress to ensure that the needs of the whole patient are addressed and opportunities to build resilience and community supports are maximized. We agree with the integration of medical and social conditions however we are unsure of the status of current assessments; what further assessment tools would be used; what resources there are to provide the significant training that might be needed; if there would need to be additional reimbursement; and what providers would do with the information.

Section 11: Oversight of Accountable Care Organizations

This section is more for the ACO to address. As stated, we do agree with the integration of medical and social services considering the research on the social determinants of health. We would want to know the financial implications, if any, of incentives.

Section 12: Trauma Training for School Nurses

We think the connection between the Trauma Informed Coordinator and school nurses is important. We are worried, however, that this position will be stretched too thin and will be too focused on training rather than systems change and improvement.

Section 13: Evidence based education and advertising fund

The marketing and analysis components make sense. We would need to learn more about the opioid related programming conducted by the PCCs. What will this look like? How it will connect, if at all, to the Preferred Provider system in the state and with the Hub and Spoke system?

Section 14: Medical Care of Inmates

We all agree that ACES screening is beneficial as part of a process. However, this process must be robust and well thought out. We currently provide a range of screenings and assessments in DOC. Some of our questions include:

- Do we have the capacity to do additional screening?

- What staff training is needed?
- Is there a system in place for the screening to be recorded and followed up on?
- What would we do with that information in a correctional setting and how would that information lead to intervention and treatment?

Section 15 Children of incarcerated parents

Regarding DCF and DOC joint referrals to children of incarcerated parents; This seems to be an expansion of DCF's role. DCF's role is to assess child safety. DCF responds to reports. Although we appreciate that having a parent incarcerated constitutes an ACE – that is not enough to compel the department to necessarily become involved. An ACE does not always equal child maltreatment. We would need to understand more about the intent here.

Section 16: Wellness Program: Advisory Council on Wellness

The Youth Risk Behavior Survey shall include questions pertaining to adverse childhood experiences: This Survey is managed by the CDC. I believe we would have to apply for changes and the CDC takes recommendations on changes from states every two years. There are modules, but they are costly to have administered. We do have considerable ACES data through the CDC and VDH which we presented to the Workgroup. We are happy to review what we have with you. We would want to explore this and alternatives further.

Section 17: Course of Study

Adding the relationship between children's brain development and early learning: We leave this to our colleagues at AOE to discuss.

Section 18: Rulemaking – Board of Professional Educators

- Amend licensure rules
- Include training in teacher and administrator licensing

We leave this to our colleagues at AOE.

Section 19: Rulemaking

At this time, we don't support amending DCF rules to require employees of registered and licensed family child care homes and center based child care and preschool programs to receive training on the use of trauma informed practices. We simply don't have the capacity and we risk asking even more of an over-burdened system. Perhaps AHS could provide access to training on a voluntary basis.

Summary

Our goal is to strengthen the trauma informed work we are doing at the Agency of Human Services including the new Building Flourishing Communities Initiative before embarking on new initiatives. We would prefer not to have a new Commission added to the work we are currently doing as we already work closely with the Child and Family Trauma Workgroup. We would rather not have additional reports that may be duplicative of our Act 43 report. We prefer

to provide annual updates on our progress to you. In addition, if we were to get a trauma informed coordinator we would like this person to focus on helping us build a more trauma informed organization more so than the varied training and administrative functions described in this legislation.

Thank you