112TH CONGRESS
1ST SESSION

# S. 54

To implement demonstration projects at federally qualified community health centers to promote universal access to family centered, evidence-based behavioral health interventions that prevent child maltreatment and promote family well-being by addressing parenting practices and skills for families from diverse socioeconomic, cultural, racial, ethnic, and other backgrounds, and for other purposes.

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IN THE SENATE OF THE UNITED STATES

JANUARY 25 (legislative day, JANUARY 5), 2011

Mr. INOUYE introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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# A BILL

To implement demonstration projects at federally qualified community health centers to promote universal access to family centered, evidence-based behavioral health interventions that prevent child maltreatment and promote family well-being by addressing parenting practices and skills for families from diverse socioeconomic, cultural, racial, ethnic, and other backgrounds, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Supporting Child Maltreatment Prevention Efforts in Community Health Centers Act of 2011''.

**SEC. 2. FINDINGS AND PURPOSES.**

(a) FINDINGS.—Congress finds as follows:

(1) Child abuse and neglect are serious public health problems in this country. During 2007, approximately 3,200,000 referrals, involving the alleged maltreatment of approximately 5,800,000 children, were sent to child protective services agencies.

(2) The most recent data show 794,000 substantiated cases of child abuse and neglect in 2007, and child maltreatment-related deaths rose 15.5 percent in 2007. Approximately 1,760 children in the United States, nearly ¾ of whom were under 4 years of age, died as a result of abuse or neglect.

(3) Early childhood experiences may have lifelong effects. Severe and chronic childhood stress, including from maltreatment and exposure to violence, is associated with persistent effects and can lead to enduring health, behavior, and learning problems.

(4) Child maltreatment has—

(A) psychological and behavioral consequences such as depression, anxiety, suicide,

aggressive behavior, delinquency, posttraumatic stress disorder, and criminal behavior;

(B) health consequences, including injuries and death, chronic obstructive pulmonary disease, smoking, heart disease, liver disease, and drug use; and

(C) developmental consequences that can compromise brain development and learning.

(5) Child maltreatment has significant financial consequences, including the short-term costs associated with case handling by child protective services and investigations, hospitalization or emergency room visits for medical treatment of injuries, out-of-home placement alternatives, services to address mental health and substance abuse problems, loss of productivity, and poor physical health requiring multiple treatments.

(6) Child maltreatment can be prevented. Given that parents and caregivers are responsible for the majority of the abuse and neglect, caregiver-focused strategies and interventions that address parenting skills and parental risk factors such as depression, substance abuse, and intimate partner violence, as well as strategies and interventions that promote family well-being are critical. Parenting practices are

amenable to change, given reasonable efforts, and the building of safe, stable, nurturing parent-child relationships is a scientifically proven strategy for the prevention of child maltreatment.

(7) Prevention of child maltreatment should have a focus on primary prevention (before any maltreatment), emphasizing community-centered and population-based strategies.

(8) Prevention of child maltreatment should focus on promoting healthy parent-child relationships and an environment that provides safe, stable, nurturing relationships for children.

(9) Primary health care is an existing and widely accessed system in which a range of prevention strategies can be implemented, and there is growing evidence that primary health care settings are promising venues in which to conduct child maltreatment prevention and behavioral health promotion programs.

(10) Community health centers (referred to in this Act as ''CHCs'') serve more than 18,000,000 individuals in the United States annually, including individuals who are poor, uninsured, hard-to-reach, and at-risk for child maltreatment.

(11) One in 5 low-income children in the United States receives health care at a CHC.

(12) CHCs are an existing network of neighborhood health clinics widely and regularly accessed by families in need that can serve as a fitting venue for child maltreatment prevention initiatives.

(13) In the last decade, behavioral issues have had an expanding presence in the portfolio of services of CHCs. Seventy percent of CHCs have some, if minimal, on-site mental health and substance abuse services. When demand exceeds capacity or on-site services do not exist, CHCs refer individuals to off-site options.

(14) The integration of behavioral health services in primary care settings is a promising framework. Evaluation results of integrated care have shown—

(A) improvement in service utilization, such as shorter waiting time and fewer sessions to complete treatment;

(B) reduction in the stigma related to mental health services; and

(C) improvement in access to services.

(b) PURPOSES.—The purposes of this Act are as follows:

(1) To fund the implementation of a minimum of 10 demonstration projects of evidence-based and promising parenting programs at federally qualified health centers.

(2) To provide universal access to a family centered integrated and voluntary services model that prevents child maltreatment and promotes family well-being and which may include:

(A) implementation of evidence-based preventive parenting skills training programs at health centers or permanent or temporary residences of caregivers to strengthen the capacity of parents to care for their children's health and well-being and promote their own ability to create safe, stable, nurturing family environments that protect children and youth from abuse and neglect and its consequences and support children's optimal social, emotional, physical, and academic development;

(B) screening to identify parental risk factors such as depression, substance abuse, and intimate partner violence that are associated with the likelihood that parents will abuse or neglect their children, and to further develop screening methods and instruments; and

(C) linkage with, and referral to, on-site individualized quality mental health services provided by trained mental health professionals for parents and caregivers screening positive for child maltreatment risk factors to help them overcome the impediments to effective parenting and change their behaviors toward child rearing and parenting.

(3) To coordinate the design and implementation of an evaluation plan to assess the impact and feasibility of integrated services model implementation at each federally qualified health center participating in the demonstration project for health outcomes, cost effectiveness, patient satisfaction, program local adaptation, reduction of child maltreatment and injuries, and improvement of parenting behaviors and family functioning.

(4) To implement critical system factors for successful implementation of the integrated services model to prevent child maltreatment. Such factors include training of a culturally and linguistically competent workforce, use of best available technology, establishment of cooperation among FQHCs participating in the demonstration project, and

building internal and external buy-in and support for the project.

(5) To coordinate the design and implementation of the cross-site system-wide evaluation plan to assess the impact and feasibility of an integrated services model on the reduction of child maltreatment and injuries, to increase a family's access to services, to evaluate the effectiveness of the response of FQHCs organizational systems to the model implemented, and to identify lessons learned and outline recommendations for system-wide areas for improvement and changes.

**SEC. 3. DEFINITIONS.**

In this Act:

(1) FEDERALLY QUALIFIED HEALTH CENTER OR FQHC.—The term ''federally qualified health center'' or ''FQHC'' means an entity receiving a grant under section 330 of the Public Health Service Act (42 U.S.C. 254b).

(2) CAREGIVERS.—The term ''caregiver'' means an adult who is the primary caregiver, including biological, adoptive, or foster parents, grandparents or other relatives, and non-custodial parents who have an ongoing relationship, and provides physical care for, 1 or more children under the age of 10. Care-

givers may be individuals who were born in, or outside of, the United States and individuals whose main language is not English, including American Indians and Alaska Natives. Caregivers may be heterosexual or homosexual, and may have learning, physical, and other disabilities.

(3) CENTER-BASED EVIDENCE-BASED PREVENTIVE PARENTING SKILLS PROGRAM.—The term ''center-based evidence-based preventative parenting skills program'' means research-based and proven, promising interventions provided and located at a health center that—

(A) have the potential for broad impact across multiple types of maltreatment, including physical and psychological abuse and neglect;

(B) are associated with effective parent behaviors and parenting practices and with reducing child behavior problems;

(C) may be expected to reduce child maltreatment rates; and

(D) may be implemented at the FQHCs.

(4) HOME VISITATION PROGRAM.—The term ''home visitation program'' means an evidence-based program in which trained professionals visit a caregiver in the permanent or temporary residence of the

caregiver, and provide a combination of information, support, or training regarding child development, parenting skills, and health-related issues.

(5) MENTAL HEALTH SERVICES.—The term ''mental health services'' means psychotherapeutic interventions offered at health centers, or off-site locations in partnership with health centers, by mental health professionals to caregivers that screen for or are referred for child maltreatment.

(6) SCREENING.—The term ''screening'' means a form of triage, using valid, culturally sensitive tools such as scales or questionnaires applied universally by trained professionals to identify caregivers who are at-risk for maltreating or neglecting children. Screening assesses parental risks for child maltreatment such as depression, substance abuse, and intimate partner violence.

**SEC. 4. GRANTS FOR DEMONSTRATION PROJECTS ON INTEGRATED FAMILY CENTERED PREVENTIVE SERVICES.**

(a) DEMONSTRATION PROJECT GRANTS.—The Secretary of Health and Human Services, acting through the Director of the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention, shall award competitive grants to eligible federally

qualified health centers to fund a minimum of 10 demonstration projects to promote—

(1) universal access to family centered, evidence-based interventions in the FQHCs that prevent child maltreatment by addressing parenting practices and skills; and

(2) behavioral health and family well-being for families from diverse socioeconomic, cultural, racial, and ethnic backgrounds, including addressing issues related to sexual orientation and individuals with disabilities.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be a federally qualified community health center; and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) USE OF GRANT FUNDS.—A federally qualified health center receiving a grant under subsection (a) may use such funds to—

(1) conduct a needs assessment for the demonstration project, including the need for proposed integrated services, the number of caregivers in-

volved, an organizational assessment, workforce capacity and needs, and technological needs;

(2) use available technologies to collect, organize, and provide access to health and mental health information of patients, and to provide referrals, train staff, monitor service delivery and outcomes, and create networking opportunities for on-site providers and others in the community;

(3) adapt and implement evidence-based parenting skills training programs for caregivers from all backgrounds who use the health center for health care and child well-visits, through on-site programs or programs operated at permanent or temporary residences and administered, supervised, and monitored by trained professionals employed by the FQHC;

(4) adapt instruments and screen caregivers for child maltreatment risk factors such as depression, substance abuse, and intimate partner violence, provided that such screening is conducted by trained professionals employed by the FQHC;

(5) provide access to mental health services to caregivers screened positive for child maltreatment risk factors, which may include services offered at the health centers or at off-site locations in partner-

ship with the health centers, and which shall be conducted by mental health professionals;

(6) promote models of integrated care that involve behavioral health specialists and primary care providers working collaboratively in integrated teams to deliver services that prevent child maltreatment and promote family well-being;

(7) develop public education campaigns to increase community awareness of the integrated services offered by the health centers; and

(8) evaluate patient satisfaction, project cost effectiveness, results of the integrated services model, and effectiveness of evidence-based parenting programs in improving parenting practices and reducing child abuse and neglect.

(d) DURATION OF GRANT.—A grant under subsection (a) shall be awarded for a period not to exceed 5 years.

(e) TECHNICAL ASSISTANCE AND PROJECT COORDINATION.—

(1) IN GENERAL.—The Secretary shall award a contract to 1 or more eligible entities to provide—

(A) technical assistance and project coordination for the recipients of grants under subsection (a);

(B) training for health care professionals, including mental health care professionals, at FQHCs that receive grants under subsection (a); and

(C) cross-site evaluation of the demonstration projects under subsection (a).

(2) ELIGIBLE ENTITIES.—To be eligible to receive a contract under this section, an entity shall—

(A) be—

(i) an institution of higher education (as defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001));

(ii) a nonprofit organization that qualifies for tax exempt status under section 501(c)(3) of the Internal Revenue Code of 1986; or

(iii) such national and professional organizations and community-based organizations as the Secretary determines appropriate;

(B) have expertise in parent-child relationships, parenting programs, prevention of child maltreatment, the integration of behavioral health in primary and community health center settings, and coordinating multi-site projects;

(C) demonstrate a defined or proposed collaboration with purveyors of evidence-based child maltreatment prevention interventions; and

(D) submit to the Secretary an application that includes—

(i) an outline of a technical assistance and coordination plan and timeline;

(ii) a description of activities, services, and strategies to be used to reach out and work with the FQHCs and others involved in the demonstration projects under subsection (a); and

(iii) a description of the evaluation methods and strategies the entity plans to use, and an outline of the progress and final reports required under subsection (f)(2).

(3) PRIORITY.—In awarding contracts under this subsection, the Secretary shall give priority to eligible entities whose applications under paragraph (2)(D) demonstrate that the evaluation design of such eligible entity uses strong experimental designs that capture a range of health and behavioral outcomes and include feasibility evaluation of the inte-

grated health-behavioral health services model. Such evaluation designs should provide evaluation results that identify lessons learned and generate recommendations for improvements and changes.

(4) AUTHORIZED ACTIVITIES.—Each recipient of a contract under this subsection shall use such award to provide technical assistance to the FQHCs receiving a grant under subsection (a) and to provide coordination and cross-site evaluation of such demonstration projects to the Secretary. Such technical assistance and coordination and cross-site evaluation may include—

(A) establishing and implementing uniform tracking and monitoring systems across FQHCs participating in the demonstration project, using the best available, highest level of technological tools;

(B) developing and implementing a cross-site, multi-level evaluation plan using rigorous research and evaluation designs to evaluate the demonstration projects across FQHCs;

(C) ensuring that, in implementing the evidence-based parenting training programs, each such FQHC follows standardized manuals and protocols, and ensuring effectiveness of the inte-

grated services of each FQHC in promoting positive stable, nurturing parent-child relationships and preventing child maltreatment and injuries;

(D) ensuring an effective and feasible evaluation of the outcomes of the demonstration projects, including an assessment of—

(i) improvement of parent knowledge of child social, emotional, cognitive development;

(ii) improvement of parent-child relationships;

(iii) parental use of positive discipline methods and effective communication skills;

(iv) health outcomes for children;

(v) reduction of incidence of child maltreatment;

(vi) cost-effectiveness of the demonstration projects;

(vii) implementation that follows standardized manuals and protocols;

(viii) the interdisciplinary collaborative model;

(ix) cultural sensitivity and local adaptation of the projects;

(x) any increase in access to services; and

(xi) further improvements and changes needed at the FQHCs;

(E) establishing and coordinating the implementation of a workforce development and training plan to ensure that professionals working at the health centers, including physicians, nurses, nurse practitioners, psychologists, social workers, physician's assistants, clinical pharmacists, and others, are trained to participate in interdisciplinary teams and work collaboratively to provide culturally competent and linguistically sensitive integrated services to all caregivers coming to such center, with a focus on the development and strengthening of—

(i) knowledge of the public health model, child development, family functioning, the problem of child maltreatment, and methods of prevention;

(ii) core attitudes, including the belief that child maltreatment is preventable, professionals have a role in prevention,

families are partners in preventing maltreatment, and evaluation is a critical element of interventions;

(iii) ability to conduct screenings, implement evidence-based parenting programs, provide mental health services, and collaborate with evaluation efforts;

(iv) ability to manage the site project, participate in interdisciplinary teams, work on integrated efforts, and master technology for best results;

(v) the knowledge, skills, and attitude to work with individuals from diverse cultural, racial, ethnic, and other backgrounds; and

(vi) an understanding of cross-field culture and language to effectively participate in interdisciplinary teams and collaborate in integrated activities;

(F) educating and involving the governing boards of FQHCs participating in the demonstration projects in the integrated service efforts;

(G) promoting partnerships with State and local institutions of higher education, commu-

nity networks, and professional associations for staff training and recruitment;

(H) promoting collaboration and networking among FQHCs participating in the demonstration projects; and

(I) establishing and coordinating child maltreatment prevention collaboratives across FQHCs participating in the demonstration projects and helping such FQHCs partner with local departments of child welfare and community mental health centers.

(5) ADVISORY GROUPS.—

(A) IN GENERAL.—Each recipient of a contract under this subsection shall establish an advisory group. Each such advisory group shall provide feedback and input to the contract recipient to ensure such recipient's effectiveness in providing quality services.

(B) MEMBERSHIP.—Each such advisory group shall be composed of representatives of—

(i) national organizations representing community health centers;

(ii) national professional organizations representing professionals from various

fields, including pediatrics, nursing, psychology, and social work; and

(iii) government agencies with relevant expertise, as determined by the Director of the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention.

(f) EVALUATION AND REPORTING.—

(1) DEMONSTRATION PROJECT REPORTING.—

(A) ANNUAL PROGRESS EVALUATION AND FINANCIAL REPORTING.—For the duration of the grant under subsection (a), each FQHC shall submit to the Secretary an annual progress evaluation and financial reporting indicating activities conducted and the progress of the health center toward achievement of established outcomes, including cost effectiveness, patient satisfaction, program local adaptation, reduction of child maltreatment and injuries, and improvement of parenting behaviors and family functioning.

(B) FINAL REPORT.—At the end of the grant period, each FQHC shall submit a final report with evaluation data analysis and conclu-

sions related to the outcomes of the demonstration project.

(2) TECHNICAL ASSISTANCE REPORTING.—

(A) ANNUAL PROGRESS AND FINANCIAL REPORT.—For the duration of the contract under subsection (e), each technical assistance provider shall submit to the Secretary an annual progress and financial report indicating activities conducted under such contract.

(B) FINAL REPORT.—At the end of the contract period, each recipient of a technical assistance contract under subsection (e) shall submit to the Secretary a final report that includes—

(i) an analysis of comparative data related to effectiveness and feasibility of projects implemented at the FQHCs, workforce training, and achievement of outcomes at the FQHCs;

(ii) overall recommendations for system improvement and changes that would allow the demonstration projects to be expanded;

(iii) an outline of the project results; and

(iv) a plan that outlines opportunities and vehicles for the dissemination of cross-site evalution results, findings, and recommendations.

(g) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—To carry out the demonstration project grant program described in subsection (a), there are authorized to be appropriated $10,000,000 for fiscal year 2012, and such sums as may be necessary for each of fiscal years 2013 through 2016.

(2) TECHNICAL ASSISTANCE.—The Secretary shall reserve not less than 10 percent of the amounts appropriated under paragraph (1) to carry out the technical assistance program described in subsection (e).

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