I

112TH CONGRESS
2D SESSION

H. R. 5841

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.

IN THE HOUSE OF REPRESENTATIVES

MAY 18, 2012

Ms. FUDGE (for herself, Mrs. CHRISTENSEN, Ms. HANABUSA, Ms. LEE of California, Ms. WILSON of Florida, Mr. RANGEL, and Ms. NORTON) introduced the following bill; which was referred to the Committee on Energy and Commerce

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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.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the ''Supporting Child Mal-
3 treatment Prevention Efforts in Community Health Cen-
4 ters Act of 2012''.

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

6 (a) FINDINGS.—Congress finds as follows:

7 (1) Child abuse and neglect are serious public
8 health problems in this country. During Federal fis-
9 cal year (FFY) 2010, an estimated 3,300,000 refer-
10 rals, involving the alleged maltreatment of approxi-
11 mately 5,900,000 children, were received by child
12 protective services agencies.

13 (2) The most recent data show 754,000 sub-
14 stantiated cases of child abuse and neglect in FFY
15 2010. Approximately 1,560 children in the United
16 States, nearly ¾ of whom were under 4 years of
17 age, died as a result of abuse or neglect. More than
18 47 percent were under the age of one.

19 (3) Early childhood experiences may have life-
20 long effects. Severe and chronic childhood stress, in-
21 cluding from maltreatment and exposure to violence,
22 is associated with persistent effects and can lead to
23 enduring health, behavior, and learning problems.

24 (4) Child maltreatment has—

25 (A) psychological and behavioral con-
26 sequences such as depression, anxiety, suicide,

1 aggressive behavior, delinquency, posttraumatic
2 stress disorder, and criminal behavior;
3 (B) health consequences, including injuries
4 and death, chronic obstructive pulmonary dis-
5 ease, smoking, heart disease, liver disease, and
6 drug use; and
7 (C) developmental consequences that can
8 compromise brain development and learning.
9 (5) Child maltreatment has significant financial
10 consequences, including the short-term costs associ-
11 ated with case handling by child protective services
12 and investigations, hospitalization or emergency
13 room visits for medical treatment of injuries, out-of-
14 home placement alternatives, services to address
15 mental health and substance abuse problems, loss of
16 productivity, and poor physical health requiring mul-
17 tiple treatments.
18 (6) Child maltreatment can be prevented. Given
19 that parents and caregivers are responsible for the
20 majority of the abuse and neglect, caregiver-focused
21 strategies and interventions that address parenting
22 skills and parental risk factors such as depression,
23 substance abuse, and intimate partner violence, as
24 well as strategies and interventions that promote
25 family well-being are critical. Parenting practices are

1 amenable to change, given reasonable efforts, and
2 the building of safe, stable, nurturing parent-child
3 relationships is a scientifically proven strategy for
4 the prevention of child maltreatment.
5 (7) Prevention of child maltreatment should
6 have a focus on primary prevention (before any mal-
7 treatment), emphasizing community-centered and
8 population-based strategies.
9 (8) Prevention of child maltreatment should
10 focus on promoting healthy parent-child relation-
11 ships and an environment that provides safe, stable,
12 nurturing relationships for children.
13 (9) Primary health care is an existing and wide-
14 ly accessed system in which a range of prevention
15 strategies can be implemented, and there is growing
16 evidence that primary health care settings are prom-
17 ising venues in which to conduct child maltreatment
18 prevention and behavioral health promotion pro-
19 grams.
20 (10) Community health centers (referred to in
21 this Act as "CHCs") serve more than 18,000,000
22 individuals in the United States annually, including
23 individuals who are poor, uninsured, hard-to-reach,
24 and at-risk for child maltreatment.

1 (11) One in 5 low-income children in the United
2 States receives health care at a CHC.
3 (12) CHCs are an existing network of neighbor-
4 hood health clinics widely and regularly accessed by
5 families in need that can serve as a fitting venue for
6 child maltreatment prevention initiatives.
7 (13) In the last decade, behavioral issues have
8 had an expanding presence in the portfolio of serv-
9 ices of CHCs. Seventy percent of CHCs have some,
10 if minimal, on-site mental health and substance
11 abuse services. When demand exceeds capacity or
12 on-site services do not exist, CHCs refer individuals
13 to off-site options.
14 (14) The integration of behavioral health serv-
15 ices in primary care settings is a promising frame-
16 work. Evaluation results of integrated care have
17 shown—
18 (A) improvement in service utilization,
19 such as shorter waiting time and fewer sessions
20 to complete treatment;
21 (B) reduction in the stigma related to
22 mental health services; and
23 (C) improvement in access to services.
24 (b) PURPOSES.—The purposes of this Act are as fol-
25 lows:

1 (1) To fund the implementation of a minimum
2 of 10 demonstration projects of evidence-based and
3 promising parenting programs at federally qualified
4 health centers.
5 (2) To provide universal access to a family cen-
6 tered integrated and voluntary services model that
7 prevents child maltreatment and promotes family
8 well-being and which may include—
9 (A) implementation of evidence-based pre-
10 ventive parenting skills training programs at
11 health centers or permanent or temporary resi-
12 dences of caregivers to strengthen the capacity
13 of parents to care for their children's health
14 and well-being and promote their own ability to
15 create safe, stable, nurturing family environ-
16 ments that protect children and youth from
17 abuse and neglect and its consequences and
18 support children's optimal social, emotional,
19 physical, and academic development;
20 (B) screening to identify parental risk fac-
21 tors such as depression, substance abuse, and
22 intimate partner violence that are associated
23 with the likelihood that parents will abuse or
24 neglect their children, and to further develop
25 screening methods and instruments; and

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

9 (3) To coordinate the design and implementa-
10 tion of an evaluation plan to assess the impact and
11 feasibility of integrated services model implementa-
12 tion at each federally qualified health center partici-
13 pating in the demonstration project for health out-
14 comes, cost effectiveness, patient satisfaction, pro-
15 gram local adaptation, reduction of child maltreat-
16 ment and injuries, and improvement of parenting be-
17 haviors and family functioning.

18 (4) To implement critical system factors for
19 successful implementation of the integrated services
20 model to prevent child maltreatment. Such factors
21 include training of a culturally and linguistically
22 competent workforce, use of best available tech-
23 nology, establishment of cooperation among FQHCs
24 participating in the demonstration project, and

1 building internal and external buy-in and support for
2 the project.
3 (5) To coordinate the design and implementa-
4 tion of the cross-site system-wide evaluation plan to
5 assess the impact and feasibility of an integrated
6 services model on the reduction of child maltreat-
7 ment and injuries, to increase a family's access to
8 services, to evaluate the effectiveness of the response
9 of FQHCs organizational systems to the model im-
10 plemented, and to identify lessons learned and out-
11 line recommendations for system-wide areas for im-
12 provement and changes.
13 **SEC. 3. DEFINITIONS.**
14 In this Act:
15 (1) FEDERALLY QUALIFIED HEALTH CENTER
16 OR FQHC.—The term ''federally qualified health cen-
17 ter'' or ''FQHC'' means an entity receiving a grant
18 under section 330 of the Public Health Service Act
19 (42 U.S.C. 254b).
20 (2) CAREGIVERS.—The term ''caregiver'' means
21 an adult who is the primary caregiver, including bio-
22 logical, adoptive, or foster parents, grandparents or
23 other relatives, and non-custodial parents who have
24 an ongoing relationship, and provides physical care
25 for one or more children under the age of 10. Care-

1 givers may be individuals who were born in, or out-
2 side of, the United States and individuals whose
3 main language is not English, including American
4 Indians and Alaska Natives. Caregivers may be het-
5 erosexual or homosexual, and may have learning,
6 physical, and other disabilities.

7 (3) CENTER-BASED EVIDENCE-BASED PREVEN-
8 TIVE PARENTING SKILLS PROGRAM.—The term
9 ''center-based evidence-based preventative parenting
10 skills program'' means research-based and proven,
11 promising interventions provided and located at a
12 health center that—

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

16 (B) are associated with effective parent be-
17 haviors and parenting practices and with reduc-
18 ing child behavior problems;

19 (C) may be expected to reduce child mal-
20 treatment rates; and

21 (D) may be implemented at the FQHCs.

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

1 caregiver, and provide a combination of information,
2 support, or training regarding child development,
3 parenting skills, and health-related issues.
4 (5) MENTAL HEALTH SERVICES.—The term
5 ''mental health services'' means psychotherapeutic
6 interventions offered at health centers, or off-site lo-
7 cations in partnership with health centers, by mental
8 health professionals to caregivers that screen for or
9 are referred for child maltreatment.
10 (6) SCREENING.—The term ''screening'' means
11 a form of triage, using valid, culturally sensitive
12 tools such as scales or questionnaires applied univer-
13 sally by trained professionals to identify caregivers
14 who are at-risk for maltreating or neglecting chil-
15 dren. Screening assesses parental risks for child
16 maltreatment such as depression, substance abuse,
17 and intimate partner violence.

18 **SEC. 4. GRANTS FOR DEMONSTRATION PROJECTS ON INTE-**
19 **GRATED FAMILY CENTERED PREVENTIVE**
20 **SERVICES.**

21 (a) DEMONSTRATION PROJECT GRANTS.—The Sec-
22 retary of Health and Human Services, acting through the
23 Director of the National Center for Injury Prevention and
24 Control of the Centers for Disease Control and Preven-
25 tion, shall award competitive grants to eligible federally

1 qualified health centers to fund a minimum of 10 dem-
2 onstration projects to promote—
3 (1) universal access to family centered, evi-
4 dence-based interventions in the FQHCs that pre-
5 vent child maltreatment by addressing parenting
6 practices and skills; and
7 (2) behavioral health and family well-being for
8 families from diverse socioeconomic, cultural, racial,
9 and ethnic backgrounds, including addressing issues
10 related to sexual orientation and individuals with
11 disabilities.
12 (b) ELIGIBILITY.—To be eligible to receive a grant
13 under subsection (a), an entity shall—
14 (1) be a federally qualified community health
15 center; and
16 (2) submit to the Secretary an application at
17 such time, in such manner, and containing such in-
18 formation as the Secretary may require.
19 (c) USE OF GRANT FUNDS.—A federally qualified
20 health center receiving a grant under subsection (a) may
21 use such funds to—
22 (1) conduct a needs assessment for the dem-
23 onstration project, including the need for proposed
24 integrated services, the number of caregivers in-

1 volved, an organizational assessment, workforce ca-
2 pacity and needs, and technological needs;
3 (2) use available technologies to collect, orga-
4 nize, and provide access to health and mental health
5 information of patients, and to provide referrals,
6 train staff, monitor service delivery and outcomes,
7 and create networking opportunities for on-site pro-
8 viders and others in the community;
9 (3) adapt and implement evidence-based par-
10 enting skills training programs for caregivers from
11 all backgrounds who use the health center for health
12 care and child well-visits, through on-site programs
13 or programs operated at permanent or temporary
14 residences and administered, supervised, and mon-
15 itored by trained professionals employed by the
16 FQHC;
17 (4) adapt instruments and screen caregivers for
18 child maltreatment risk factors such as depression,
19 substance abuse, and intimate partner violence, pro-
20 vided that such screening is conducted by trained
21 professionals employed by the FQHC;
22 (5) provide access to mental health services to
23 caregivers screened positive for child maltreatment
24 risk factors, which may include services offered at
25 the health centers or at off-site locations in partner-

1 ship with the health centers, and which shall be con-
2 ducted by mental health professionals;
3 (6) promote models of integrated care that in-
4 volve behavioral health specialists and primary care
5 providers working collaboratively in integrated teams
6 to deliver services that prevent child maltreatment
7 and promote family well-being;
8 (7) develop public education campaigns to in-
9 crease community awareness of the integrated serv-
10 ices offered by the health centers; and
11 (8) evaluate patient satisfaction, project cost ef-
12 fectiveness, results of the integrated services model,
13 and effectiveness of evidence-based parenting pro-
14 grams in improving parenting practices and reducing
15 child abuse and neglect.
16 (d) DURATION OF GRANT.—A grant under sub-
17 section (a) shall be awarded for a period not to exceed
18 5 years.
19 (e) TECHNICAL ASSISTANCE AND PROJECT COORDI-
20 NATION.—
21 (1) IN GENERAL.—The Secretary shall award a
22 contract to one or more eligible entities to provide—
23 (A) technical assistance and project coordi-
24 nation for the recipients of grants under sub-
25 section (a);

1 (B) training for health care professionals,
2 including mental health care professionals, at
3 FQHCs that receive grants under subsection
4 (a); and
5 (C) cross-site evaluation of the demonstra-
6 tion projects under subsection (a).
7 (2) ELIGIBLE ENTITIES.—To be eligible to re-
8 ceive a contract under this section, an entity shall—
9 (A) be—
10 (i) an institution of higher education
11 (as defined in section 101 of the Higher
12 Education Act of 1965 (20 U.S.C. 1001));
13 (ii) a nonprofit organization that
14 qualifies for tax exempt status under sec-
15 tion 501(c)(3) of the Internal Revenue
16 Code of 1986; or
17 (iii) such national and professional or-
18 ganizations and community-based organi-
19 zations as the Secretary determines appro-
20 priate;
21 (B) have expertise in parent-child relation-
22 ships, parenting programs, prevention of child
23 maltreatment, the integration of behavioral
24 health in primary and community health center
25 settings, and coordinating multi-site projects;

1 (C) demonstrate a defined or proposed col-
2 laboration with purveyors of evidence-based
3 child maltreatment prevention interventions;
4 and
5 (D) submit to the Secretary an application
6 that includes—
7 (i) an outline of a technical assistance
8 and coordination plan and timeline;
9 (ii) a description of activities, services,
10 and strategies to be used to reach out and
11 work with the FQHCs and others involved
12 in the demonstration projects under sub-
13 section (a); and
14 (iii) a description of the evaluation
15 methods and strategies the entity plans to
16 use, and an outline of the progress and
17 final reports required under subsection
18 (f)(2).
19 (3) PRIORITY.—In awarding contracts under
20 this subsection, the Secretary shall give priority to
21 eligible entities whose applications under paragraph
22 (2)(D) demonstrate that the evaluation design of
23 such eligible entity uses strong experimental designs
24 that capture a range of health and behavioral out-
25 comes and include feasibility evaluation of the inte-

1 grated health-behavioral health services model. Such
2 evaluation designs should provide evaluation results
3 that identify lessons learned and generate rec-
4 ommendations for improvements and changes.

5 (4) AUTHORIZED ACTIVITIES.—Each recipient
6 of a contract under this subsection shall use such
7 award to provide technical assistance to the FQHCs
8 receiving a grant under subsection (a) and to pro-
9 vide coordination and cross-site evaluation of such
10 demonstration projects to the Secretary. Such tech-
11 nical assistance and coordination and cross-site eval-
12 uation may include—

13 (A) establishing and implementing uniform
14 tracking and monitoring systems across FQHCs
15 participating in the demonstration project,
16 using the best available, highest level of techno-
17 logical tools;

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

22 (C) ensuring that, in implementing the evi-
23 dence-based parenting training programs, each
24 such FQHC follows standardized manuals and
25 protocols, and ensuring effectiveness of the inte-

1 grated services of each FQHC in promoting
2 positive stable, nurturing parent-child relation-
3 ships and preventing child maltreatment and in-
4 juries;
5 (D) ensuring an effective and feasible eval-
6 uation of the outcomes of the demonstration
7 projects, including an assessment of—
8 (i) improvement of parent knowledge
9 of child social, emotional, cognitive devel-
10 opment;
11 (ii) improvement of parent-child rela-
12 tionships;
13 (iii) parental use of positive discipline
14 methods and effective communication
15 skills;
16 (iv) health outcomes for children;
17 (v) reduction of incidence of child
18 maltreatment;
19 (vi) cost-effectiveness of the dem-
20 onstration projects;
21 (vii) implementation that follows
22 standardized manuals and protocols;
23 (viii) the interdisciplinary collaborative
24 model;

1 (ix) cultural sensitivity and local ad-
2 aptation of the projects;
3 (x) any increase in access to services;
4 and
5 (xi) further improvements and
6 changes needed at the FQHCs;
7 (E) establishing and coordinating the im-
8 plementation of a workforce development and
9 training plan to ensure that professionals work-
10 ing at the health centers, including physicians,
11 nurses, nurse practitioners, psychologists, social
12 workers, physician's assistants, clinical phar-
13 macists, and others, are trained to participate
14 in interdisciplinary teams and work collabo-
15 ratively to provide culturally competent and lin-
16 guistically sensitive integrated services to all
17 caregivers coming to such center, with a focus
18 on the development and strengthening of—
19 (i) knowledge of the public health
20 model, child development, family func-
21 tioning, the problem of child maltreatment,
22 and methods of prevention;
23 (ii) core attitudes, including the belief
24 that child maltreatment is preventable,
25 professionals have a role in prevention,

1 families are partners in preventing mal-
2 treatment, and evaluation is a critical ele-
3 ment of interventions;
4 (iii) ability to conduct screenings, im-
5 plement evidence-based parenting pro-
6 grams, provide mental health services, and
7 collaborate with evaluation efforts;
8 (iv) ability to manage the site project,
9 participate in interdisciplinary teams, work
10 on integrated efforts, and master tech-
11 nology for best results;
12 (v) the knowledge, skills, and attitude
13 to work with individuals from diverse cul-
14 tural, racial, ethnic, and other back-
15 grounds; and
16 (vi) an understanding of cross-field
17 culture and language to effectively partici-
18 pate in interdisciplinary teams and collabo-
19 rate in integrated activities;
20 (F) educating and involving the governing
21 boards of FQHCs participating in the dem-
22 onstration projects in the integrated service ef-
23 forts;
24 (G) promoting partnerships with State and
25 local institutions of higher education, commu-

1 nity networks, and professional associations for
2 staff training and recruitment;
3 (H) promoting collaboration and net-
4 working among FQHCs participating in the
5 demonstration projects; and
6 (I) establishing and coordinating child mal-
7 treatment prevention collaboratives across
8 FQHCs participating in the demonstration
9 projects and helping such FQHCs partner with
10 local departments of child welfare and commu-
11 nity mental health centers.
12 (5) ADVISORY GROUPS.—
13 (A) IN GENERAL.—Each recipient of a
14 contract under this subsection shall establish an
15 advisory group. Each such advisory group shall
16 provide feedback and input to the contract re-
17 cipient to ensure such recipient's effectiveness
18 in providing quality services.
19 (B) MEMBERSHIP.—Each such advisory
20 group shall be composed of representatives of—
21 (i) national organizations representing
22 community health centers;
23 (ii) national professional organizations
24 representing professionals from various

1 fields, including pediatrics, nursing, psy-
2 chology, and social work; and
3 (iii) government agencies with rel-
4 evant expertise, as determined by the Di-
5 rector of the National Center for Injury
6 Prevention and Control of the Centers for
7 Disease Control and Prevention.
8 (f) EVALUATION AND REPORTING.—
9 (1) DEMONSTRATION PROJECT REPORTING.—
10 (A) ANNUAL PROGRESS EVALUATION AND
11 FINANCIAL REPORTING.—For the duration of
12 the grant under subsection (a), each FQHC
13 shall submit to the Secretary an annual
14 progress evaluation and financial reporting indi-
15 cating activities conducted and the progress of
16 the health center toward achievement of estab-
17 lished outcomes, including cost effectiveness,
18 patient satisfaction, program local adaptation,
19 reduction of child maltreatment and injuries,
20 and improvement of parenting behaviors and
21 family functioning.
22 (B) FINAL REPORT.—At the end of the
23 grant period, each FQHC shall submit a final
24 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

1 (iv) a plan that outlines opportunities
2 and vehicles for the dissemination of cross-
3 site evaluation results, findings, and rec-
4 ommendations.

5 (g) AUTHORIZATION OF APPROPRIATIONS.—

6 (1) IN GENERAL.—To carry out the demonstra-
7 tion project grant program described in subsection
8 (a), there are authorized to be appropriated
9 $10,000,000 for fiscal year 2013, and such sums as
10 may be necessary for each of fiscal years 2014
11 through 2017.

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

○