

Government to take an active role in encouraging all women to abstain from alcohol consumption during pregnancy.

“(c) PURPOSE.—It is the purpose of this section [enacting this part and provisions set out as a note under section 201 of this title] to establish, within the Department of Health and Human Services, a comprehensive program to help prevent Fetal Alcohol Syndrome and Fetal Alcohol Effect nationwide and to provide effective intervention programs and services for children, adolescents and adults already affected by these conditions. Such program shall—

“(1) coordinate, support, and conduct national, State, and community-based public awareness, prevention, and education programs on Fetal Alcohol Syndrome and Fetal Alcohol Effect;

“(2) coordinate, support, and conduct prevention and intervention studies as well as epidemiologic research concerning Fetal Alcohol Syndrome and Fetal Alcohol Effect;

“(3) coordinate, support and conduct research and demonstration projects to develop effective developmental and behavioral interventions and programs that foster effective advocacy, educational and vocational training, appropriate therapies, counseling, medical and mental health, and other supportive services, as well as models that integrate or coordinate such services, aimed at the unique challenges facing individuals with Fetal Alcohol Syndrome or Fetal Alcohol Effect and their families; and

“(4) foster coordination among all Federal, State and local agencies, and promote partnerships between research institutions and communities that conduct or support Fetal Alcohol Syndrome and Fetal Alcohol Effect research, programs, surveillance, prevention, and interventions and otherwise meet the general needs of populations already affected or at risk of being impacted by Fetal Alcohol Syndrome and Fetal Alcohol Effect.”

### § 280f-1. Eligibility

To be eligible to receive a grant, or enter into a cooperative agreement or contract under this part, an entity shall—

(1) be a State, Indian tribal government, local government, scientific or academic institution, or nonprofit organization; and

(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may prescribe, including a description of the activities that the entity intends to carry out using amounts received under this part.

(July 1, 1944, ch. 373, title III, §399I, formerly §399H, as added Pub. L. 105-392, title IV, §419(d), Nov. 13, 1998, 112 Stat. 3594; renumbered §399I, Pub. L. 106-310, div. A, title V, §502(4)(A), Oct. 17, 2000, 114 Stat. 1115.)

#### PRIOR PROVISIONS

A prior section 399I of act July 1, 1944, was renumbered section 399C and is classified to section 280e-1 of this title.

Another prior section 399I of act July 1, 1944, was renumbered section 399J and is classified to section 280f-2 of this title.

### § 280f-2. Authorization of appropriations

#### (a) In general

There are authorized to be appropriated to carry out this part, \$27,000,000 for each of the fiscal years 1999 through 2003.

#### (b) Task Force

From amounts appropriated for a fiscal year under subsection (a) of this section, the Sec-

retary may use not to exceed \$2,000,000 of such amounts for the operations of the National Task Force under section 280f(d) of this title.

(July 1, 1944, ch. 373, title III, §399J, formerly §399I, as added Pub. L. 105-392, title IV, §419(d), Nov. 13, 1998, 112 Stat. 3595; renumbered §399J and amended Pub. L. 106-310, div. A, title V, §502(4)(A), (C), Oct. 17, 2000, 114 Stat. 1115.)

#### PRIOR PROVISIONS

A prior section 399J of act July 1, 1944, was renumbered section 399D and is classified to section 280e-2 of this title.

Another prior section 399J of act July 1, 1944, was renumbered section 399K and is classified to section 280f-3 of this title.

#### AMENDMENTS

2000—Subsec. (b). Pub. L. 106-310, §502(4)(C), made technical amendment to reference in original act which appears in text as reference to section 280f(d) of this title.

### § 280f-3. Sunset provision

This part shall not apply on the date that is 7 years after the date on which all members of the National Task Force have been appointed under section 280f(d)(1) of this title.

(July 1, 1944, ch. 373, title III, §399K, formerly §399J, as added Pub. L. 105-392, title IV, §419(d), Nov. 13, 1998, 112 Stat. 3595; renumbered §399K and amended Pub. L. 106-310, div. A, title V, §502(4)(A), (D), Oct. 17, 2000, 114 Stat. 1115.)

#### PRIOR PROVISIONS

A prior section 399K of act July 1, 1944, was renumbered section 399E and is classified to section 280e-3 of this title.

#### AMENDMENTS

2000—Pub. L. 106-310, §502(4)(D), made technical amendment to reference in original act which appears in text as reference to section 280f(d)(1) of this title.

#### PART P—ADDITIONAL PROGRAMS

### § 280g. Children’s asthma treatment grants program

#### (a) Authority to make grants

##### (1) In general

In addition to any other payments made under this chapter or title V of the Social Security Act [42 U.S.C. 701 et seq.], the Secretary shall award grants to eligible entities to carry out the following purposes:

(A) To provide access to quality medical care for children who live in areas that have a high prevalence of asthma and who lack access to medical care.

(B) To provide on-site education to parents, children, health care providers, and medical teams to recognize the signs and symptoms of asthma, and to train them in the use of medications to treat asthma and prevent its exacerbations.

(C) To decrease preventable trips to the emergency room by making medication available to individuals who have not previously had access to treatment or education in the management of asthma.

(D) To provide other services, such as smoking cessation programs, home modi-

fication, and other direct and support services that ameliorate conditions that exacerbate or induce asthma.

**(2)<sup>1</sup> Certain projects**

In making grants under paragraph (1), the Secretary may make grants designed to develop and expand the following projects:

(A) Projects to provide comprehensive asthma services to children in accordance with the guidelines of the National Asthma Education and Prevention Program (through the National Heart, Lung and Blood Institute), including access to care and treatment for asthma in a community-based setting.

(B) Projects to fully equip mobile health care clinics that provide preventive asthma care including diagnosis, physical examinations, pharmacological therapy, skin testing, peak flow meter testing, and other asthma-related health care services.

(C) Projects to conduct validated asthma management education programs for patients with asthma and their families, including patient education regarding asthma management, family education on asthma management, and the distribution of materials, including displays and videos, to reinforce concepts presented by medical teams.

**(2)<sup>1</sup> Award of grants**

**(A) Application**

**(i) In general**

An eligible entity shall submit an application to the Secretary for a grant under this section in such form and manner as the Secretary may require.

**(ii) Required information**

An application submitted under this subparagraph shall include a plan for the use of funds awarded under the grant and such other information as the Secretary may require.

**(B) Requirement**

In awarding grants under this section, the Secretary shall give preference to eligible entities that demonstrate that the activities to be carried out under this section shall be in localities within areas of known or suspected high prevalence of childhood asthma or high asthma-related mortality or high rate of hospitalization or emergency room visits for asthma (relative to the average asthma prevalence rates and associated mortality rates in the United States). Acceptable data sets to demonstrate a high prevalence of childhood asthma or high asthma-related mortality may include data from Federal, State, or local vital statistics, claims data under title XIX or XXI of the Social Security Act [42 U.S.C. 1396 et seq., 1397aa et seq.], other public health statistics or surveys, or other data that the Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, deems appropriate.

**(3) Definition of eligible entity**

For purposes of this section, the term “eligible entity” means a public or nonprofit private entity (including a State or political subdivision of a State), or a consortium of any of such entities.

**(b) Coordination with other children’s programs**

An eligible entity shall identify in the plan submitted as part of an application for a grant under this section how the entity will coordinate operations and activities under the grant with—

(1) other programs operated in the State that serve children with asthma, including any such programs operated under title V, XIX, or XXI of the Social Security Act [42 U.S.C. 701 et seq., 1396 et seq., 1397aa et seq.]; and

(2) one or more of the following—

(A) the child welfare and foster care and adoption assistance programs under parts B and E of title IV of such Act [42 U.S.C. 620 et seq., 670 et seq.];

(B) the head start program established under the Head Start Act (42 U.S.C. 9831 et seq.);

(C) the program of assistance under the special supplemental nutrition program for women, infants and children (WIC) under section 1786 of this title;

(D) local public and private elementary or secondary schools; or

(E) public housing agencies, as defined in section 1437a of this title.

**(c) Evaluation**

An eligible entity that receives a grant under this section shall submit to the Secretary an evaluation of the operations and activities carried out under the grant that includes—

(1) a description of the health status outcomes of children assisted under the grant;

(2) an assessment of the utilization of asthma-related health care services as a result of activities carried out under the grant;

(3) the collection, analysis, and reporting of asthma data according to guidelines prescribed by the Director of the Centers for Disease Control and Prevention; and

(4) such other information as the Secretary may require.

**(d) Preference for States that allow students to self-administer medication to treat asthma and anaphylaxis**

**(1) Preference**

The Secretary, in making any grant under this section or any other grant that is asthma-related (as determined by the Secretary) to a State, shall give preference to any State that satisfies the following:

**(A) In general**

The State must require that each public elementary school and secondary school in that State will grant to any student in the school an authorization for the self-administration of medication to treat that student’s asthma or anaphylaxis, if—

(i) a health care practitioner prescribed the medication for use by the student dur-

<sup>1</sup> So in original. Two pars. (2) have been enacted.

ing school hours and instructed the student in the correct and responsible use of the medication;

(ii) the student has demonstrated to the health care practitioner (or such practitioner's designee) and the school nurse (if available) the skill level necessary to use the medication and any device that is necessary to administer such medication as prescribed;

(iii) the health care practitioner formulates a written treatment plan for managing asthma or anaphylaxis episodes of the student and for medication use by the student during school hours; and

(iv) the student's parent or guardian has completed and submitted to the school any written documentation required by the school, including the treatment plan formulated under clause (iii) and other documents related to liability.

**(B) Scope**

An authorization granted under subparagraph (A) must allow the student involved to possess and use his or her medication—

- (i) while in school;
- (ii) while at a school-sponsored activity, such as a sporting event; and
- (iii) in transit to or from school or school-sponsored activities.

**(C) Duration of authorization**

An authorization granted under subparagraph (A)—

- (i) must be effective only for the same school and school year for which it is granted; and
- (ii) must be renewed by the parent or guardian each subsequent school year in accordance with this subsection.

**(D) Backup medication**

The State must require that backup medication, if provided by a student's parent or guardian, be kept at a student's school in a location to which the student has immediate access in the event of an asthma or anaphylaxis emergency.

**(E) Maintenance of information**

The State must require that information described in subparagraphs (A)(iii) and (A)(iv) be kept on file at the student's school in a location easily accessible in the event of an asthma or anaphylaxis emergency.

**(2) Rule of construction**

Nothing in this subsection creates a cause of action or in any other way increases or diminishes the liability of any person under any other law.

**(3) Definitions**

For purposes of this subsection:

(A) The terms "elementary school" and "secondary school" have the meaning given to those terms in section 7801 of title 20.

(B) The term "health care practitioner" means a person authorized under law to prescribe drugs subject to section 353(b) of title 21.

(C) The term "medication" means a drug as that term is defined in section 321 of title

21 and includes inhaled bronchodilators and auto-injectable epinephrine.

(D) The term "self-administration" means a student's discretionary use of his or her prescribed asthma or anaphylaxis medication, pursuant to a prescription or written direction from a health care practitioner.

**(e) Authorization of appropriations**

For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

(July 1, 1944, ch. 373, title III, §399L, as added Pub. L. 106-310, div. A, title V, §501, Oct. 17, 2000, 114 Stat. 1113; amended Pub. L. 108-377, §3(a), Oct. 30, 2004, 118 Stat. 2203.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (a)(1), (2)(B) and (b)(1), (2)(A), is act Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended. Parts B and E of title IV of the Act are classified generally to parts B (§620 et seq.) and E (§670 et seq.), respectively, of subchapter IV of chapter 7 of this title. Titles V, XIX, and XXI of the Act are classified generally to subchapters V (§701 et seq.), XIX (§1396 et seq.), and XXI (§1397aa et seq.), respectively, of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

The Head Start Act, referred to in subsec. (b)(2)(B), is subchapter B (§§635-657) of chapter 8 of subtitle A of title VI of Pub. L. 97-35, Aug. 13, 1981, 95 Stat. 499, as amended, which is classified generally to subchapter II (§9831 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 9801 of this title and Tables.

PRIOR PROVISIONS

A prior section 399L of act July 1, 1944, was renumbered section 399F and is classified to section 280e-4 of this title.

AMENDMENTS

2004—Subsecs. (d), (e). Pub. L. 108-377 added subsec. (d) and redesignated former subsec. (d) as (e).

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108-377, §3(b), Oct. 30, 2004, 118 Stat. 2204, provided that: "The amendments made by this section [amending this section] shall apply only with respect to grants made on or after the date that is 9 months after the date of the enactment of this Act [Oct. 30, 2004]."

FINDINGS OF 2004 AMENDMENT

Pub. L. 108-377, §2, Oct. 30, 2004, 118 Stat. 2202, provided that: "The Congress finds the following:

- "(1) Asthma is a chronic condition requiring lifetime, ongoing medical intervention.
- "(2) In 1980, 6,700,000 Americans had asthma.
- "(3) In 2001, 20,300,000 Americans had asthma; 6,300,000 children under age 18 had asthma.
- "(4) The prevalence of asthma among African-American children was 40 percent greater than among Caucasian children, and more than 26 percent of all asthma deaths are in the African-American population.
- "(5) In 2000, there were 1,800,000 asthma-related visits to emergency departments (more than 728,000 of these involved children under 18 years of age).
- "(6) In 2000, there were 465,000 asthma-related hospitalizations (214,000 of these involved children under 18 years of age).
- "(7) In 2000, 4,487 people died from asthma, and of these 223 were children.
- "(8) According to the Centers for Disease Control and Prevention, asthma is a common cause of missed

school days, accounting for approximately 14,000,000 missed school days annually.

“(9) According to the New England Journal of Medicine, working parents of children with asthma lose an estimated \$1,000,000,000 a year in productivity.

“(10) At least 30 States have legislation protecting the rights of children to carry and self-administer asthma metered-dose inhalers, and at least 18 States expand this protection to epinephrine auto-injectors.

“(11) Tragic refusals of schools to permit students to carry their inhalers and auto-injectable epinephrine have occurred, some resulting in death and spawning litigation.

“(12) School district medication policies must be developed with the safety of all students in mind. The immediate and correct use of asthma inhalers and auto-injectable epinephrine are necessary to avoid serious respiratory complications and improve health care outcomes.

“(13) No school should interfere with the patient-physician relationship.

“(14) Anaphylaxis, or anaphylactic shock, is a systemic allergic reaction that can kill within minutes. Anaphylaxis occurs in some asthma patients. According to the American Academy of Allergy, Asthma, and Immunology, people who have experienced symptoms of anaphylaxis previously are at risk for subsequent reactions and should carry an epinephrine auto-injector with them at all times, if prescribed.

“(15) An increasing number of students and school staff have life-threatening allergies. Exposure to the affecting allergen can trigger anaphylaxis. Anaphylaxis requires prompt medical intervention with an injection of epinephrine.”

**§ 280g-1. Early detection, diagnosis, and treatment regarding hearing loss in infants**

**(a) Statewide newborn and infant hearing screening, evaluation and intervention programs and systems**

The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall make awards of grants or cooperative agreements to develop statewide newborn and infant hearing screening, evaluation and intervention programs and systems for the following purposes:

(1) To develop and monitor the efficacy of state-wide newborn and infant hearing screening, evaluation and intervention programs and systems. Early intervention includes referral to schools and agencies, including community, consumer, and parent-based agencies and organizations and other programs mandated by part C of the Individuals with Disabilities Education Act [20 U.S.C. 1431 et seq.], which offer programs specifically designed to meet the unique language and communication needs of deaf and hard of hearing newborns, infants, toddlers, and children.

(2) To collect data on statewide newborn and infant hearing screening, evaluation and intervention programs and systems that can be used for applied research, program evaluation and policy development.

**(b) Technical assistance, data management, and applied research**

**(1) Centers for Disease Control and Prevention**

The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall make awards of grants or cooperative agreements to provide technical assistance to State agencies to complement an in-

tramural program and to conduct applied research related to newborn and infant hearing screening, evaluation and intervention programs and systems. The program shall develop standardized procedures for data management and program effectiveness and costs, such as—

(A) to ensure quality monitoring of newborn and infant hearing loss screening, evaluation, and intervention programs and systems;

(B) to provide technical assistance on data collection and management;

(C) to study the costs and effectiveness of newborn and infant hearing screening, evaluation and intervention programs and systems conducted by State-based programs in order to answer issues of importance to State and national policymakers;

(D) to identify the causes and risk factors for congenital hearing loss;

(E) to study the effectiveness of newborn and infant hearing screening, audiologic and medical evaluations and intervention programs and systems by assessing the health, intellectual and social developmental, cognitive, and language status of these children at school age; and

(F) to promote the sharing of data regarding early hearing loss with State-based birth defects and developmental disabilities monitoring programs for the purpose of identifying previously unknown causes of hearing loss.

**(2) National Institutes of Health**

The Director of the National Institutes of Health, acting through the Director of the National Institute on Deafness and Other Communication Disorders, shall for purposes of this section, continue a program of research and development on the efficacy of new screening techniques and technology, including clinical studies of screening methods, studies on efficacy of intervention, and related research.

**(c) Coordination and collaboration**

**(1) In general**

In carrying out programs under this section, the Administrator of the Health Resources and Services Administration, the Director of the Centers for Disease Control and Prevention, and the Director of the National Institutes of Health shall collaborate and consult with other Federal agencies; State and local agencies, including those responsible for early intervention services pursuant to title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] (Medicaid Early and Periodic Screening, Diagnosis and Treatment Program); title XXI of the Social Security Act [42 U.S.C. 1397aa et seq.] (State Children’s Health Insurance Program); title V of the Social Security Act [42 U.S.C. 701 et seq.] (Maternal and Child Health Block Grant Program); and part C of the Individuals with Disabilities Education Act [20 U.S.C. 1431 et seq.]; consumer groups of and that serve individuals who are deaf and hard-of-hearing and their families; appropriate national medical and other health and education specialty organizations; persons who are deaf

and hard-of-hearing and their families; other qualified professional personnel who are proficient in deaf or hard-of-hearing children's language and who possess the specialized knowledge, skills, and attributes needed to serve deaf and hard-of-hearing newborns, infants, toddlers, children, and their families; third-party payers and managed care organizations; and related commercial industries.

**(2) Policy development**

The Administrator of the Health Resources and Services Administration, the Director of the Centers for Disease Control and Prevention, and the Director of the National Institutes of Health shall coordinate and collaborate on recommendations for policy development at the Federal and State levels and with the private sector, including consumer, medical and other health and education professional-based organizations, with respect to newborn and infant hearing screening, evaluation and intervention programs and systems.

**(3) State early detection, diagnosis, and intervention programs and systems; data collection**

The Administrator of the Health Resources and Services Administration and the Director of the Centers for Disease Control and Prevention shall coordinate and collaborate in assisting States to establish newborn and infant hearing screening, evaluation and intervention programs and systems under subsection (a) of this section and to develop a data collection system under subsection (b) of this section.

**(d) Rule of construction; religious accommodation**

Nothing in this section shall be construed to preempt or prohibit any State law, including State laws which do not require the screening for hearing loss of newborn infants or young children of parents who object to the screening on the grounds that such screening conflicts with the parents' religious beliefs.

**(e) Definitions**

For purposes of this section:

(1) The term "audiologic evaluation" refers to procedures to assess the status of the auditory system; to establish the site of the auditory disorder; the type and degree of hearing loss, and the potential effects of hearing loss on communication; and to identify appropriate treatment and referral options. Referral options should include linkage to State coordinating agencies under part C of the Individuals with Disabilities Education Act [20 U.S.C. 1431 et seq.] or other appropriate agencies, medical evaluation, hearing aid/sensory aid assessment, audiologic rehabilitation treatment, national and local consumer, self-help, parent, and education organizations, and other family-centered services.

(2) The terms "audiologic rehabilitation" and "audiologic intervention" refer to procedures, techniques, and technologies to facilitate the receptive and expressive communication abilities of a child with hearing loss.

(3) The term "early intervention" refers to providing appropriate services for the child

with hearing loss, including nonmedical services, and ensuring that families of the child are provided comprehensive, consumer-oriented information about the full range of family support, training, information services, communication options and are given the opportunity to consider the full range of educational and program placements and options for their child.

(4) The term "medical evaluation by a physician" refers to key components including history, examination, and medical decision making focused on symptomatic and related body systems for the purpose of diagnosing the etiology of hearing loss and related physical conditions, and for identifying appropriate treatment and referral options.

(5) The term "medical intervention" refers to the process by which a physician provides medical diagnosis and direction for medical and/or surgical treatment options of hearing loss and/or related medical disorder associated with hearing loss.

(6) The term "newborn and infant hearing screening" refers to objective physiologic procedures to detect possible hearing loss and to identify newborns and infants who, after re-screening, require further audiologic and medical evaluations.

**(f) Authorization of appropriations**

**(1) Statewide newborn and infant hearing screening, evaluation and intervention programs and systems**

For the purpose of carrying out subsection (a) of this section, there are authorized to be appropriated to the Health Resources and Services Administration such sums as may be necessary for fiscal year 2002.

**(2) Technical assistance, data management, and applied research; Centers for Disease Control and Prevention**

For the purpose of carrying out subsection (b)(1) of this section, there are authorized to be appropriated to the Centers for Disease Control and Prevention such sums as may be necessary for fiscal year 2002.

**(3) Technical assistance, data management, and applied research; national institute on deafness and other communication disorders**

For the purpose of carrying out subsection (b)(2) of this section, there are authorized to be appropriated to the National Institute on Deafness and Other Communication Disorders such sums as may be necessary for fiscal year 2002.

(July 1, 1944, ch. 373, title III, §399M, as added Pub. L. 106-310, div. A, title VII, §702, Oct. 17, 2000, 114 Stat. 1121.)

REFERENCES IN TEXT

The Individuals with Disabilities Education Act, referred to in subsecs. (a)(1), (c)(1), and (e)(1), is title VI of Pub. L. 91-230, Apr. 13, 1970, 84 Stat. 175, as amended. Part C of the Act is classified generally to subchapter III (§1431 et seq.) of chapter 33 of Title 20, Education. For complete classification of this Act to the Code, see section 1400 of Title 20 and Tables.

The Social Security Act, referred to in subsec. (c)(1), is act Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended.

Titles V, XIX, and XXI of the Act are classified generally to subchapters V (§701 et seq.), XIX (§1396 et seq.), and XXI (§1397aa et seq.), respectively, of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

#### PURPOSES

Pub. L. 106-310, div. A, title VII, §701, Oct. 17, 2000, 114 Stat. 1120, provided that: "The purposes of this title [enacting this section] are to clarify the authority within the Public Health Service Act [this chapter] to authorize statewide newborn and infant hearing screening, evaluation and intervention programs and systems, technical assistance, a national applied research program, and interagency and private sector collaboration for policy development, in order to assist the States in making progress toward the following goals:

"(1) All babies born in hospitals in the United States and its territories should have a hearing screening before leaving the birthing facility. Babies born in other countries and residing in the United States via immigration or adoption should have a hearing screening as early as possible.

"(2) All babies who are not born in hospitals in the United States and its territories should have a hearing screening within the first 3 months of life.

"(3) Appropriate audiologic and medical evaluations should be conducted by 3 months for all newborns and infants suspected of having hearing loss to allow appropriate referral and provisions for audiologic rehabilitation, medical and early intervention before the age of 6 months.

"(4) All newborn and infant hearing screening programs and systems should include a component for audiologic rehabilitation, medical and early intervention options that ensures linkage to any new and existing state-wide systems of intervention and rehabilitative services for newborns and infants with hearing loss.

"(5) Public policy in regard to newborn and infant hearing screening and intervention should be based on applied research and the recognition that newborns, infants, toddlers, and children who are deaf or hard-of-hearing have unique language, learning, and communication needs, and should be the result of consultation with pertinent public and private sectors."

### § 280g-2. Childhood malignancies

#### (a) In general

The Secretary, acting as appropriate through the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health, shall study environmental and other risk factors for childhood cancers (including skeletal malignancies, leukemias, malignant tumors of the central nervous system, lymphomas, soft tissue sarcomas, and other malignant neoplasms) and carry out projects to improve outcomes among children with childhood cancers and resultant secondary conditions, including limb loss, anemia, rehabilitation, and palliative care. Such projects shall be carried out by the Secretary directly and through awards of grants or contracts.

#### (b) Certain activities

Activities under subsection (a) of this section include—

(1) the expansion of current demographic data collection and population surveillance efforts to include childhood cancers nationally;

(2) the development of a uniform reporting system under which treating physicians, hospitals, clinics, and States report the diagnosis of childhood cancers, including relevant associated epidemiological data; and

(3) support for the National Limb Loss Information Center to address, in part, the primary and secondary needs of persons who experience childhood cancers in order to prevent or minimize the disabling nature of these cancers.

#### (c) Coordination of activities

The Secretary shall assure that activities under this section are coordinated as appropriate with other agencies of the Public Health Service that carry out activities focused on childhood cancers and limb loss.

#### (d) Definition

For purposes of this section, the term "childhood cancer" refers to a spectrum of different malignancies that vary by histology, site of disease, origin, race, sex, and age. The Secretary may for purposes of this section revise the definition of such term to the extent determined by the Secretary to be appropriate.

#### (e) Authorization of appropriations

For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

(July 1, 1944, ch. 373, title III, §399N, as added Pub. L. 106-310, div. A, title XI, §1101, Oct. 17, 2000, 114 Stat. 1131.)

### § 280g-3. Controlled substance monitoring program

#### (a) Grants

##### (1) In general

Each fiscal year, the Secretary shall award a grant to each State with an application approved under this section to enable the State—

- (A) to establish and implement a State controlled substance monitoring program; or
- (B) to make improvements to an existing State controlled substance monitoring program.

##### (2) Determination of amount

###### (A) Minimum amount

In making payments under a grant under paragraph (1) for a fiscal year, the Secretary shall allocate to each State with an application approved under this section an amount that equals 1.0 percent of the amount appropriated to carry out this section for that fiscal year.

###### (B) Additional amounts

In making payments under a grant under paragraph (1) for a fiscal year, the Secretary shall allocate to each State with an application approved under this section an additional amount which bears the same ratio to the amount appropriated to carry out this section for that fiscal year and remaining after amounts are made available under subparagraph (A) as the number of pharmacies of the State bears to the number of pharmacies of all States with applications approved under this section (as determined by the Secretary), except that the Secretary may adjust the amount allocated to a State under this subparagraph after taking into consideration the budget cost estimate for

the State's controlled substance monitoring program.

**(3) Term of grants**

Grants awarded under this section shall be obligated in the year in which funds are allotted.

**(b) Development of minimum requirements**

Prior to awarding a grant under this section, and not later than 6 months after the date on which funds are first appropriated to carry out this section, after seeking consultation with States and other interested parties, the Secretary shall, after publishing in the Federal Register proposed minimum requirements and receiving public comments, establish minimum requirements for criteria to be used by States for purposes of clauses (ii), (v), (vi), and (vii) of subsection (c)(1)(A) of this section.

**(c) Application approval process**

**(1) In general**

To be eligible to receive a grant under this section, a State shall submit an application to the Secretary at such time, in such manner, and containing such assurances and information as the Secretary may reasonably require. Each such application shall include—

(A) with respect to a State that intends to use funds under the grant as provided for in subsection (a)(1)(A) of this section—

(i) a budget cost estimate for the controlled substance monitoring program to be implemented under the grant;

(ii) criteria for security for information handling and for the database maintained by the State under subsection (e) of this section generally including efforts to use appropriate encryption technology or other appropriate technology to protect the security of such information;

(iii) an agreement to adopt health information interoperability standards, including health vocabulary and messaging standards, that are consistent with any such standards generated or identified by the Secretary or his or her designee;

(iv) criteria for meeting the uniform electronic format requirement of subsection (h) of this section;

(v) criteria for availability of information and limitation on access to program personnel;

(vi) criteria for access to the database, and procedures to ensure that information in the database is accurate;

(vii) criteria for the use and disclosure of information, including a description of the certification process to be applied to requests for information under subsection (f) of this section;

(viii) penalties for the unauthorized use and disclosure of information maintained in the State controlled substance monitoring program in violation of applicable State law or regulation;

(ix) information on the relevant State laws, policies, and procedures, if any, regarding purging of information from the database; and

(x) assurances of compliance with all other requirements of this section; or

(B) with respect to a State that intends to use funds under the grant as provided for in subsection (a)(1)(B) of this section—

(i) a budget cost estimate for the controlled substance monitoring program to be improved under the grant;

(ii) a plan for ensuring that the State controlled substance monitoring program is in compliance with the criteria and penalty requirements described in clauses (ii) through (viii) of subparagraph (A);

(iii) a plan to enable the State controlled substance monitoring program to achieve interoperability with at least one other State controlled substance monitoring program; and

(iv) assurances of compliance with all other requirements of this section or a statement describing why such compliance is not feasible or is contrary to the best interests of public health in such State.

**(2) State legislation**

As part of an application under paragraph (1), the Secretary shall require a State to demonstrate that the State has enacted legislation or regulations to permit the implementation of the State controlled substance monitoring program and the imposition of appropriate penalties for the unauthorized use and disclosure of information maintained in such program.

**(3) Interoperability**

If a State that submits an application under this subsection geographically borders another State that is operating a controlled substance monitoring program under subsection (a)(1) of this section on the date of submission of such application, and such applicant State has not achieved interoperability for purposes of information sharing between its monitoring program and the monitoring program of such border State, such applicant State shall, as part of the plan under paragraph (1)(B)(iii), describe the manner in which the applicant State will achieve interoperability between the monitoring programs of such States.

**(4) Approval**

If a State submits an application in accordance with this subsection, the Secretary shall approve such application.

**(5) Return of funds**

If the Secretary withdraws approval of a State's application under this section, or the State chooses to cease to implement or improve a controlled substance monitoring program under this section, a funding agreement for the receipt of a grant under this section is that the State will return to the Secretary an amount which bears the same ratio to the overall grant as the remaining time period for expending the grant funds bears to the overall time period for expending the grant (as specified by the Secretary at the time of the grant).

**(d) Reporting requirements**

In implementing or improving a controlled substance monitoring program under this section, a State shall comply, or with respect to a State that applies for a grant under subsection

(a)(1)(B) of this section submit to the Secretary for approval a statement of why such compliance is not feasible or is contrary to the best interests of public health in such State, with the following:

(1) The State shall require dispensers to report to such State each dispensing in the State of a controlled substance to an ultimate user not later than 1 week after the date of such dispensing.

(2) The State may exclude from the reporting requirement of this subsection—

(A) the direct administration of a controlled substance to the body of an ultimate user;

(B) the dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less; or

(C) the administration or dispensing of a controlled substance in accordance with any other exclusion identified by the Secretary for purposes of this paragraph.

(3) The information to be reported under this subsection with respect to the dispensing of a controlled substance shall include the following:

(A) Drug Enforcement Administration Registration Number (or other identifying number used in lieu of such Registration Number) of the dispenser.

(B) Drug Enforcement Administration Registration Number (or other identifying number used in lieu of such Registration Number) and name of the practitioner who prescribed the drug.

(C) Name, address, and telephone number of the ultimate user or such contact information of the ultimate user as the Secretary determines appropriate.

(D) Identification of the drug by a national drug code number.

(E) Quantity dispensed.

(F) Number of refills ordered.

(G) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(H) Date of the dispensing.

(I) Date of origin of the prescription.

(J) Such other information as may be required by State law to be reported under this subsection.

(4) The State shall require dispensers to report information under this section in accordance with the electronic format specified by the Secretary under subsection (h) of this section, except that the State may waive the requirement of such format with respect to an individual dispenser that is unable to submit such information by electronic means.

**(e) Database**

In implementing or improving a controlled substance monitoring program under this section, a State shall comply with the following:

(1) The State shall establish and maintain an electronic database containing the information reported to the State under subsection (d) of this section.

(2) The database must be searchable by any field or combination of fields.

(3) The State shall include reported information in the database in a manner consistent with criteria established by the Secretary, with appropriate safeguards for ensuring the accuracy and completeness of the database.

(4) The State shall take appropriate security measures to protect the integrity of, and access to, the database.

**(f) Use and disclosure of information**

**(1) In general**

Subject to subsection (g) of this section, in implementing or improving a controlled substance monitoring program under this section, a State may disclose information from the database established under subsection (e) of this section and, in the case of a request under subparagraph (D), summary statistics of such information, only in response to a request by—

(A) a practitioner (or the agent thereof) who certifies, under the procedures determined by the State, that the requested information is for the purpose of providing medical or pharmaceutical treatment or evaluating the need for such treatment to a bona fide current patient;

(B) any local, State, or Federal law enforcement, narcotics control, licensure, disciplinary, or program authority, who certifies, under the procedures determined by the State, that the requested information is related to an individual investigation or proceeding involving the unlawful diversion or misuse of a schedule II, III, or IV substance, and such information will further the purpose of the investigation or assist in the proceeding;

(C) the controlled substance monitoring program of another State or group of States with whom the State has established an interoperability agreement;

(D) any agent of the Department of Health and Human Services, a State medicaid program, a State health department, or the Drug Enforcement Administration who certifies that the requested information is necessary for research to be conducted by such department, program, or administration, respectively, and the intended purpose of the research is related to a function committed to such department, program, or administration by law that is not investigative in nature; or

(E) an agent of the State agency or entity of another State that is responsible for the establishment and maintenance of that State's controlled substance monitoring program, who certifies that—

(i) the State has an application approved under this section; and

(ii) the requested information is for the purpose of implementing the State's controlled substance monitoring program under this section.

**(2) Drug diversion**

In consultation with practitioners, dispensers, and other relevant and interested stakeholders, a State receiving a grant under subsection (a) of this section—

(A) shall establish a program to notify practitioners and dispensers of information

that will help identify and prevent the unlawful diversion or misuse of controlled substances; and

(B) may, to the extent permitted under State law, notify the appropriate authorities responsible for carrying out drug diversion investigations if the State determines that information in the database maintained by the State under subsection (e) of this section indicates an unlawful diversion or abuse of a controlled substance.

**(g) Limitations**

In implementing or improving a controlled substance monitoring program under this section, a State—

(1) shall limit the information provided pursuant to a valid request under subsection (f)(1) of this section to the minimum necessary to accomplish the intended purpose of the request; and

(2) shall limit information provided in response to a request under subsection (f)(1)(D) of this section to nonidentifiable information.

**(h) Electronic format**

The Secretary shall specify a uniform electronic format for the reporting, sharing, and disclosure of information under this section.

**(i) Rules of construction**

**(1) Functions otherwise authorized by law**

Nothing in this section shall be construed to restrict the ability of any authority, including any local, State, or Federal law enforcement, narcotics control, licensure, disciplinary, or program authority, to perform functions otherwise authorized by law.

**(2) No preemption**

Nothing in this section shall be construed as preempting any State law, except that no such law may relieve any person of a requirement otherwise applicable under this chapter.

**(3) Additional privacy protections**

Nothing in this section shall be construed as preempting any State from imposing any additional privacy protections.

**(4) Federal privacy requirements**

Nothing in this section shall be construed to supersede any Federal privacy or confidentiality requirement, including the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191; 110 Stat. 2033) and section 290dd-2 of this title.

**(5) No Federal private cause of action**

Nothing in this section shall be construed to create a Federal private cause of action.

**(j) Studies and reports**

**(1) Implementation report**

**(A) In general**

Not later than 180 days after August 11, 2005, the Secretary, based on a review of existing State controlled substance monitoring programs and other relevant information, shall determine whether the implementation of such programs has had a substantial negative impact on—

(i) patient access to treatment, including therapy for pain or controlled substance abuse;

(ii) pediatric patient access to treatment; or

(iii) patient enrollment in research or clinical trials in which, following the protocol that has been approved by the relevant institutional review board for the research or clinical trial, the patient has obtained a controlled substance from either the scientific investigator conducting such research or clinical trial or the agent thereof.

**(B) Additional categories of exclusion**

If the Secretary determines under subparagraph (A) that a substantial negative impact has been demonstrated with regard to one or more of the categories of patients described in such subparagraph, the Secretary shall identify additional appropriate categories of exclusion from reporting as authorized under subsection (d)(2)(C) of this section.

**(2) Progress report**

Not later than 3 years after the date on which funds are first appropriated under this section, the Secretary shall—

(A) complete a study that—

(i) determines the progress of States in establishing and implementing controlled substance monitoring programs under this section;

(ii) provides an analysis of the extent to which the operation of controlled substance monitoring programs have reduced inappropriate use, abuse, or diversion of controlled substances or affected patient access to appropriate pain care in States operating such programs;

(iii) determines the progress of States in achieving interoperability between controlled substance monitoring programs, including an assessment of technical and legal barriers to such activities and recommendations for addressing these barriers;

(iv) determines the feasibility of implementing a real-time electronic controlled substance monitoring program, including the costs associated with establishing such a program;

(v) provides an analysis of the privacy protections in place for the information reported to the controlled substance monitoring program in each State receiving a grant for the establishment or operation of such program, and any recommendations for additional requirements for protection of this information;

(vi) determines the feasibility of implementing technological alternatives to centralized data storage, such as peer-to-peer file sharing or data pointer systems, in controlled substance monitoring programs and the potential for such alternatives to enhance the privacy and security of individually identifiable data; and

(vii) evaluates the penalties that States have enacted for the unauthorized use and disclosure of information maintained in the controlled substance monitoring pro-

gram, and reports on the criteria used by the Secretary to determine whether such penalties qualify as appropriate pursuant to this section; and

(B) submit a report to the Congress on the results of the study.

**(k) Preference**

Beginning 3 years after the date on which funds are first appropriated to carry out this section, the Secretary, in awarding any competitive grant that is related to drug abuse (as determined by the Secretary) and for which only States are eligible to apply, shall give preference to any State with an application approved under this section. The Secretary shall have the discretion to apply such preference to States with existing controlled substance monitoring programs that meet minimum requirements under this section or to States that put forth a good faith effort to meet those requirements (as determined by the Secretary).

**(l) Advisory council**

**(1) Establishment**

A State may establish an advisory council to assist in the establishment, implementation, or improvement of a controlled substance monitoring program under this section.

**(2) Limitation**

A State may not use amounts received under a grant under this section for the operations of an advisory council established under paragraph (1).

**(3) Sense of Congress**

It is the sense of the Congress that, in establishing an advisory council under this subsection, a State should consult with appropriate professional boards and other interested parties.

**(m) Definitions**

For purposes of this section:

(1) The term “bona fide patient” means an individual who is a patient of the practitioner involved.

(2) The term “controlled substance” means a drug that is included in schedule II, III, or IV of section 812(c) of title 21.

(3) The term “dispense” means to deliver a controlled substance to an ultimate user by, or pursuant to the lawful order of, a practitioner, irrespective of whether the dispenser uses the Internet or other means to effect such delivery.

(4) The term “dispenser” means a physician, pharmacist, or other person that dispenses a controlled substance to an ultimate user.

(5) The term “interoperability” with respect to a State controlled substance monitoring program means the ability of the program to electronically share reported information, including each of the required report components described in subsection (d) of this section, with another State if the information concerns either the dispensing of a controlled substance to an ultimate user who resides in such other State, or the dispensing of a controlled substance prescribed by a practitioner whose principal place of business is located in such other State.

(6) The term “nonidentifiable information” means information that does not identify a practitioner, dispenser, or an ultimate user and with respect to which there is no reasonable basis to believe that the information can be used to identify a practitioner, dispenser, or an ultimate user.

(7) The term “practitioner” means a physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he or she practices or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

(8) The term “State” means each of the 50 States and the District of Columbia.

(9) The term “ultimate user” means a person who has obtained from a dispenser, and who possesses, a controlled substance for his or her own use, for the use of a member of his or her household, or for the use of an animal owned by him or her or by a member of his or her household.

**(n) Authorization of appropriations**

To carry out this section, there are authorized to be appropriated—

(1) \$15,000,000 for each of fiscal years 2006 and 2007; and

(2) \$10,000,000 for each of fiscal years 2008, 2009, and 2010.

(July 1, 1944, ch. 373, title III, §399O, as added Pub. L. 109–60, §3, Aug. 11, 2005, 119 Stat. 1979.)

REFERENCES IN TEXT

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (i)(4), is section 264(c) of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

PRIOR PROVISIONS

Another section 399O of act July 1, 1944, was renumbered section 399P and is classified to section 280g–4 of this title.

PURPOSE

Pub. L. 109–60, §2, Aug. 11, 2005, 119 Stat. 1979, provided that: “It is the purpose of this Act [enacting this section and provisions set out as a note under section 201 of this title] to—

“(1) foster the establishment of State-administered controlled substance monitoring systems in order to ensure that health care providers have access to the accurate, timely prescription history information that they may use as a tool for the early identification of patients at risk for addiction in order to initiate appropriate medical interventions and avert the tragic personal, family, and community consequences of untreated addiction; and

“(2) establish, based on the experiences of existing State controlled substance monitoring programs, a set of best practices to guide the establishment of new State programs and the improvement of existing programs.”

**§ 280g-4. Grants to foster public health responses to domestic violence, dating violence, sexual assault, and stalking**

**(a) Authority to award grants**

**(1) In general**

The Secretary, acting through the Director of the Centers for Disease Control and Preven-

tion, shall award grants to eligible State, tribal, territorial, or local entities to strengthen the response of State, tribal, territorial, or local health care systems to domestic violence, dating violence, sexual assault, and stalking.

**(2) Eligible entities**

To be eligible to receive a grant under this section, an entity shall—

(A) be—

(i) a State department (or other division) of health, a State domestic or sexual assault coalition or service-based program, State law enforcement task force, or any other nonprofit, nongovernmental, tribal, territorial, or State entity with a history of effective work in the fields of domestic violence, dating violence, sexual assault or stalking, and health care; or

(ii) a local, nonprofit domestic violence, dating violence, sexual assault, or stalking service-based program, a local department (or other division) of health, a local health clinic, hospital, or health system, or any other nonprofit, tribal, or local entity with a history of effective work in the field of domestic or sexual violence and health;

(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such agreements, assurances, and information as the Secretary determines to be necessary to carry out the purposes for which the grant is to be made; and

(C) demonstrate that the entity is representing a team of organizations and agencies working collaboratively to strengthen the response of the health care system involved to domestic violence, dating violence, sexual assault, or stalking and that such team includes domestic violence, dating violence, sexual assault or stalking and health care organizations.

**(3) Duration**

A program conducted under a grant awarded under this section shall not exceed 2 years.

**(b) Use of funds**

**(1) In general**

An entity shall use amounts received under a grant under this section to design and implement comprehensive strategies to improve the response of the health care system involved to domestic or sexual violence in clinical and public health settings, hospitals, clinics, managed care settings (including behavioral and mental health), and other health settings.

**(2) Mandatory strategies**

Strategies implemented under paragraph (1) shall include the following:

(A) The implementation, dissemination, and evaluation of policies and procedures to guide health care professionals and behavioral and public health staff in responding to domestic violence, dating violence, sexual assault, and stalking, including strategies to ensure that health information is maintained in a manner that protects the patient's privacy and safety and prohibits insurance discrimination.

(B) The development of on-site access to services to address the safety, medical, mental health, and economic needs of patients either by increasing the capacity of existing health care professionals and behavioral and public health staff to address domestic violence, dating violence, sexual assault, and stalking, by contracting with or hiring domestic or sexual assault advocates to provide the services, or to model other services appropriate to the geographic and cultural needs of a site.

(C) The evaluation of practice and the institutionalization of identification, intervention, and documentation including quality improvement measurements.

(D) The provision of training and followup technical assistance to health care professionals, behavioral and public health staff, and allied health professionals to identify, assess, treat, and refer clients who are victims of domestic violence, dating violence, sexual violence, or stalking.

**(3) Permissive strategies**

Strategies implemented under paragraph (1) may include the following:

(A) Where appropriate, the development of training modules and policies that address the overlap of child abuse, domestic violence, dating violence, sexual assault, and stalking and elder abuse as well as childhood exposure to domestic violence.

(B) The creation, adaptation, and implementation of public education campaigns for patients concerning domestic violence, dating violence, sexual assault, and stalking prevention.

(C) The development, adaptation, and dissemination of domestic violence, dating violence, sexual assault, and stalking education materials to patients and health care professionals and behavioral and public health staff.

(D) The promotion of the inclusion of domestic violence, dating violence, sexual assault, and stalking into health professional training schools, including medical, dental, nursing school, social work, and mental health curriculum.

(E) The integration of domestic violence, dating violence, sexual assault, and stalking into health care accreditation and professional licensing examinations, such as medical, dental, social work, and nursing boards.

**(c) Allocation of funds**

Funds appropriated under this section shall be distributed equally between State and local programs.

**(d) Authorization of appropriations**

There is authorized to be appropriated to award grants under this section, \$5,000,000 for each of fiscal years 2007 through 2011.

(July 1, 1944, ch. 373, title III, §399P, formerly §399O, as added Pub. L. 109-162, title V, §504, Jan. 5, 2006, 119 Stat. 3026; renumbered §399P, Pub. L. 109-450, §4(1), Dec. 22, 2006, 120 Stat. 3342.)

## FINDINGS

Pub. L. 109-162, title V, §501, Jan. 5, 2006, 119 Stat. 3023, provided that: “Congress makes the following findings:

“(1) The health-related costs of intimate partner violence in the United States exceed \$5,800,000,000 annually.

“(2) Thirty-seven percent of all women who sought care in hospital emergency rooms for violence-related injuries were injured by a current or former spouse, boyfriend, or girlfriend.

“(3) In addition to injuries sustained during violent episodes, physical and psychological abuse is linked to a number of adverse physical and mental health effects. Women who have been abused are much more likely to suffer from chronic pain, diabetes, depression, unintended pregnancies, substance abuse and sexually transmitted infections, including HIV/AIDS.

“(4) Health plans spend an average of \$1,775 more a year on abused women than on general enrollees.

“(5) Each year about 324,000 pregnant women in the United States are battered by the men in their lives. This battering leads to complications of pregnancy, including low weight gain, anemia, infections, and first and second trimester bleeding.

“(6) Pregnant and recently pregnant women are more likely to be victims of homicide than to die of any other pregnancy-related cause, and evidence exists that a significant proportion of all female homicide victims are killed by their intimate partners.

“(7) Children who witness domestic violence are more likely to exhibit behavioral and physical health problems including depression, anxiety, and violence towards peers. They are also more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in teenage prostitution, and commit sexual assault crimes.

“(8) Recent research suggests that women experiencing domestic violence significantly increase their safety-promoting behaviors over the short- and long-term when health care providers screen for, identify, and provide followup care and information to address the violence.

“(9) Currently, only about 10 percent of primary care physicians routinely screen for intimate partner abuse during new patient visits and 9 percent routinely screen for intimate partner abuse during periodic checkups.

“(10) Recent clinical studies have proven the effectiveness of a 2-minute screening for early detection of abuse of pregnant women. Additional longitudinal studies have tested a 10-minute intervention that was proven highly effective in increasing the safety of pregnant abused women. Comparable research does not yet exist to support the effectiveness of screening men.

“(11) Seventy to 81 percent of the patients studied reported that they would like their healthcare providers to ask them privately about intimate partner violence.”

## PURPOSE

Pub. L. 109-162, title V, §502, Jan. 5, 2006, 119 Stat. 3024, provided that: “It is the purpose of this title [enacting this section, sections 294h and 13973 of this title, and provisions set out as a note above] to improve the health care system’s response to domestic violence, dating violence, sexual assault, and stalking through the training and education of health care providers, developing comprehensive public health responses to violence against women and children, increasing the number of women properly screened, identified, and treated for lifetime exposure to violence, and expanding research on effective interventions in the health care setting.”

### § 280g-5. Public and health care provider education and support services

#### (a) In general

The Secretary, directly or through the awarding of grants to public or private nonprofit entities, may conduct demonstration projects for the purpose of improving the provision of information on prematurity to health professionals and other health care providers and the public and improving the treatment and outcomes for babies born preterm.

#### (b) Activities

Activities to be carried out under the demonstration project under subsection (a) may include the establishment of—

(1) programs to test and evaluate various strategies to provide information and education to health professionals, other health care providers, and the public concerning—

(A) the signs of preterm labor, updated as new research results become available;

(B) the screening for and the treating of infections;

(c)<sup>1</sup> counseling on optimal weight and good nutrition, including folic acid;

(D) smoking cessation education and counseling;

(E) stress management; and

(F) appropriate prenatal care;

(2) programs to improve the treatment and outcomes for babies born premature, including the use of evidence-based standards of care by health care professionals for pregnant women at risk of preterm labor or other serious complications and for infants born preterm and at a low birthweight;

(3) programs to respond to the informational needs of families during the stay of an infant in a neonatal intensive care unit, during the transition of the infant to the home, and in the event of a newborn death; and

(4) such other programs as the Secretary determines appropriate to achieve the purpose specified in subsection (a).

#### (c) Authorization of appropriations

There is authorized to be appropriated to carry out this section \$5,000,000 for each of fiscal years 2007 through 2011.

(July 1, 1944, ch. 373, title III, §399Q, as added Pub. L. 109-450, §4(2), Dec. 22, 2006, 120 Stat. 3342.)

#### PART Q—PROGRAMS TO IMPROVE THE HEALTH OF CHILDREN

### § 280h. Grants to promote childhood nutrition and physical activity

#### (a) In general

The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award competitive grants to States and political subdivisions of States for the development and implementation of State and community-based intervention programs to promote good nutrition and physical activity in children and adolescents.

<sup>1</sup> So in original. Probably should be “(C)”.